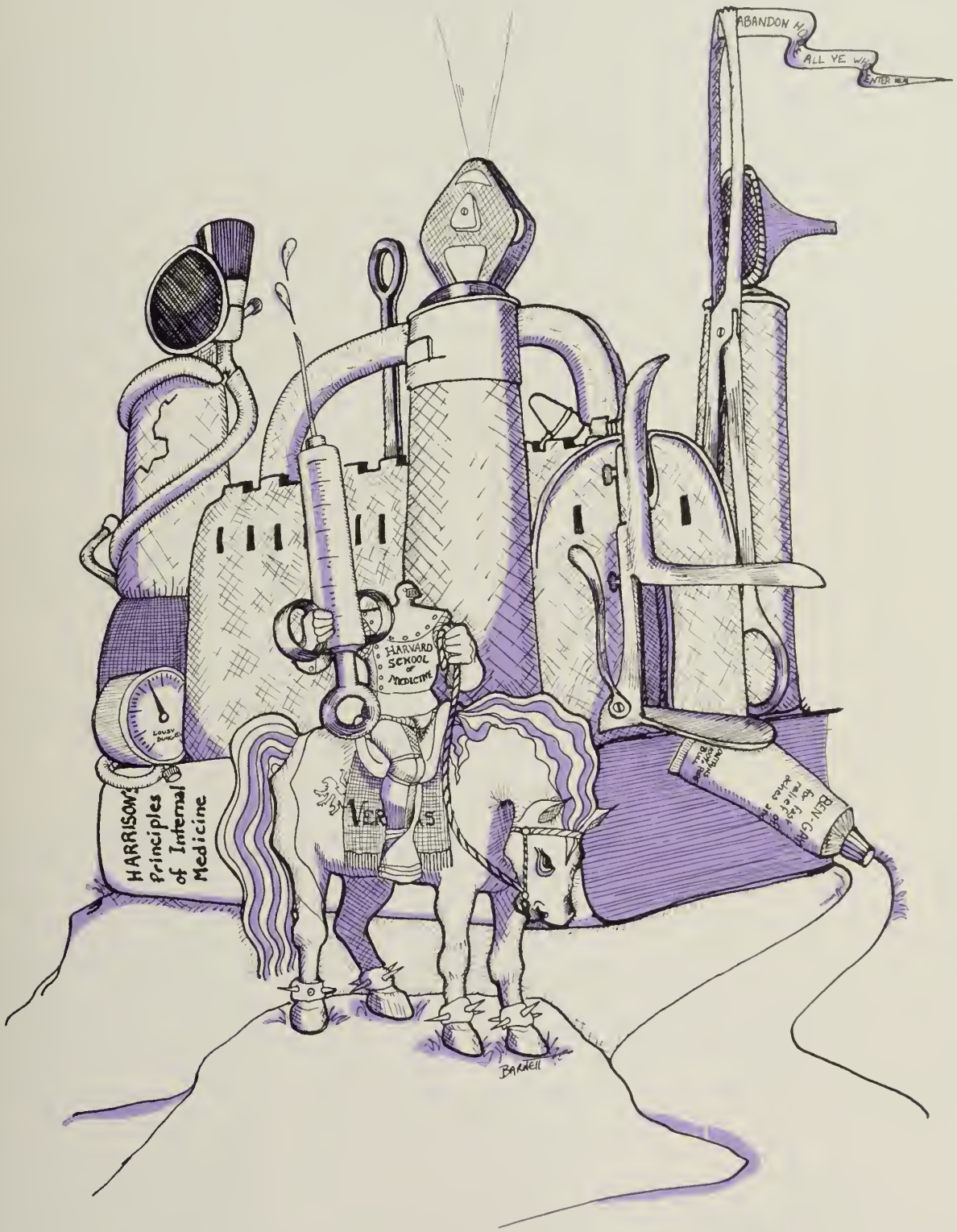
Harvard Medical Alumni Bulletin

May/June 1977



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Harvard Medical Alumni Bulletin

may/june 1977 vol. 51, no. 5

The *Harvard Medical Alumni Bulletin* is published bi-monthly at 25 Shattuck St., Boston, Mass. 02115. Third class postage paid at Burlington, Vermont

This issue of the HMAB focuses on some of the sidelights that can enrich, exacerbate, or provide relief from the usual curriculum: taking an extra year to do research, grappling with money problems, competing for a good residency, learning to regard sleep as a luxury during residency, creating Rabelaisian comedy through the second year show. Students contributed heavily to this student oriented issue as authors, photographers, illustrators, even models. We found that they boast of myriad talents, especially when they must confront the rising costs of living and learning. An example is Marguerite Barnett '79 (left), who is responsible for our cover drawing (originally used on the program for *Cramalot*, the second year show) and several other illustrations. A devotee of belly dancing since learning it at the age of eight in Algeria, she occasionally supplements her income by performing at a local Middle Eastern restaurant. Other mainstays of her budget are laboratory work, cocktail waitressing, and her educational stipend as an Army lieutenant — which she will repay with five years' service as an "Army doc." For more on how other students, with help from HMS, pay their bills, turn to p. 31. Articles about the race for and rigors of residency begin on p. 12.

Credits: Cover, p. 24-27, 31, 33, Marguerite Barnett '79; p. 1, 32, Deborah W. Miller; p. 2, Diane Andronica; p. 3, Rick Stafford; p. 7, 13-16, 30, 44, David Gunner; p. 8-11, David States '79; p. 21, 23, courtesy of John S. Graettinger '45; p. 29, Victoria L. Johnson; p. 48, courtesy of Downstate Medical Center.

Overview

The guests of the evening were (left to right) Dr. Barger, Dr. Nemiah, Dr. Tosteson, Dr. Altschule, Dr. Castle (standing), Dr. Prout, Dr. Cahill, Dr. Ingelfinger, Dr. Moore, and Dr. Scannell.

"The Best of the Boylston"

At Harvard Medical School, said Dr. Francis Moore, a person will give a speech if two other people remain seated. On the occasion at which he spoke — the March 2 meeting of the Boylston Society — there was an abundance of speakers, a standing-room-only audience, and a wealth of wit, erudition and reminiscence. Ten distinguished alumni and faculty members had been brought together in a nostalgic presentation entitled "The Best of the Boylston."

Seated in a semicircle facing their enthusiastic audience of students, faculty and staff, the honored guests were: William Castle '21, Mark Altschule '32, Franz Ingelfinger '36, Francis Moore '39, J. Gordon Scannell '40, Curtis Prout '41, A. Clifford Barger '43A, John Nemiah '43B, Daniel Tosteson '49, and George Cahill, Jr. The Boylston Society's student co-chairmen, John Curnutte '77 and Thomas Mustoe '77, had arranged this assemblage of former student members and faculty presidents to review the Society's past through their own remembrances of it.

A reminiscence related by Dr. Altschule may be typical of the experience of many Boylston Society members. In 1940 Dr. Altschule, who was twice a student president of the Society, had delivered a Boylston paper — on the physiology of fever — which was "received all over the world with complete indifference." Thirty-one years later, he said, "it was received with worldwide acclaim." The moral? "Don't throw your grandmother's hat away, it may come back into fashion."

Dr. Barger spoke of a period when Boylston Society members had been immersed in local politics. During his presidency in the early 1940s, Massachusetts medical students had joined scientists in lobbying against the anti-vivisectionists for the use of animals in research. Their efforts might have proven fruitless, were it not for an unpleasant urological ailment that beset a certain highly placed political personage. His urologist, after effecting a fervently desired cure, encouraged his patient's gratitude with equal skill. With that official's tireless partisanship, the necessary laws permitting animal research were passed.

Dr. Moore, who at last year's Class Day put himself forward as a citizen of the year 2000, now harked back to the battlegrounds of the Civil War. He did not, however, claim to have been there any earlier than the 1930s, when he visited Chancellorsville and The Wilderness, and interviewed Harvardians whose fathers had been surgeons in the war — in preparation for a Boylston speech on Civil War surgery.

"Herman Melville and the Great White Whale" was the paper with which Dr. Tosteson had regaled the Boylston Society some nineteen years ago — a study of the physiology of diving mammals. A member of the younger generation among the guests — having been the student of several of the other speakers — the new dean praised the Society for bringing students and teachers together for such a stimulating forum.

The highlights of the evening were many more than can be recapitulated here. The unusual event more than lived up to its title, "The Best of the Boylston."

Harvard Community Health Plan: a promising future

Now in its ninth year, with a membership of over 60,000, the Harvard Community Health Plan is looking to its future. New administrative arrangements are making possible substantial savings, and HCHP's long-range planning committee, chaired by Dean Robert H. Ebert, has just made public a report outlining eight major areas of concentration for the organization's resources and energies during the next decade.

In January of this year, HCHP began to phase out a seven year relationship with Blue Cross of Massachusetts. Prior to the enactment of the State Health Maintenance Organization Act in October 1976, HCHP had to be regulated through an insurance company. The Act, however, permitted health maintenance organizations to enter into direct contract with their members, removing the need for insurance company involvement. HCHP estimates that over the seven year period it has paid $2.5 million for Blue Cross to take charge of administrative, marketing and billing services to some fifteen hundred members. HCHP has always covered the hospitalization costs of its member hospitals, while Blue Cross retained responsibility for the majority of out-of-area claims. When the Plan was organized, an established intermediary was necessary, but because of its secure position, HCHP can now process its own bills, pay its own claims, and save approximately $750,000 in its first year of independence from Blue Cross.

The set of priorities put forward by HCHP's long-range planning committee gives precedence to consideration of a new health plan center in the Greater Boston area, and enrollment of more members from low-income groups, blue collar workers, and the elderly. In keeping with the concern for these groups, the report urged that HCHP continue its involvement in the Mission Hill community surrounding the Medical School, where it now maintains an outreach center. HCHP should hold its costs down, the committee recommended, so that the plan remains at least twenty per cent less expensive than a comparable benefit plan such as Blue Cross/Blue Shield, when total out-of-pocket expenditures are taken into account.

In addition, the committee advised that HCHP consolidate emergency and specialty services, provide more of these services through the plan, and develop relations with other community medical facilities. Continued emphasis on health education and residency training was also recommended.

"Prince" earns Pulitzer Prize

A twelve-year odyssey, ranging from the quiet village streets of Tremadoc, Wales to the historically embattled shores of the Gulf of Aqaba, from the orderly repositories of Oxford's Bodleian Library to the dim labyrinths of the human psyche, has led to a Pulitzer Prize for John Mack '55, professor of psychiatry. His achievement is a scholarly 562-page psychological biography of the Englishman who led the Arab revolt against Turkish domination during the first world war: *A Prince of Our Disorder: The Life of T. E. Lawrence.**

"There is a need to know more about the psychological development, strengths, vulnerabilities of leaders," states Dr. Mack, who heads Harvard's psychiatry department at the Cambridge Hospital and is director of education at the Cambridge-Somerville Mental Health Center. As a psychoanalyst, he was singularly equipped to conduct such an exploration — and Lawrence of Arabia was a particularly suitable subject. "I became hooked by Lawrence because he was extraordinary for a public figure, a military commander, in the degree to which he was involved with exploring his *own* inner life. Lawrence, *himself* asked what was propelling him, what was the meaning of what he was doing, what was his own purpose in getting involved with the Arab revolt, how did it relate to his own personal development. He was interested in the relationship of his adult actions to his youthful readings of chivalric romances: how they related to his concerns with the Crusade, his ideas of heroism, redemption, renunciation, self-sacrifice. He explored all of this in *Seven Pillars of Wisdom*, and in his correspondence. He also had a great gift for psychological insight."

Dr. Mack

Dr. Mack interviewed hundreds of people for his book — among them Howeitat tribesmen of Jordan, and two of the architects of T. E. Lawrence's almost superhuman popular image, American journalist Lowell Thomas, and British military expert and historian, Basil Liddell Hart, author of the original *Lawrence of Arabia*. Crucial to the project was the cooperation of Lawrence's brothers — the elder a medical missionary, and the younger an archeologist who, as literary executor of T. E. Lawrence's estate, worked closely with Dr. Mack over a period of ten years.

"I think psychiatric training and experience in working with psychological histories is helpful in terms of the necessity for interweaving the themes that occur in Lawrence's life," reflects Dr. Mack. "Psychiatric training does not help you in learning history — that you have to do on your own — but it does help you in interviewing." The author admits having encountered some mistrust on account of his profession — "but the funny part of it is that despite people's suspicion, they nevertheless would end up pouring out a great deal of information, saying: 'Well, since you're a psychiatrist, you'd certainly be interested in this. . . .' "

A Prince of Our Disorder is Dr. Mack's first biographical venture; he has authored a classic psychiatric text, *Nightmares and Human Conflict*, and is the

editor of *Borderline States in Psychiatry.* The residence to which he returned between transatlantic research forays and camel-back pilgrimages is in nearby Chestnut Hill, Massachusetts, where he lives with his wife, Sally, a psychiatric social worker, and their three sons.

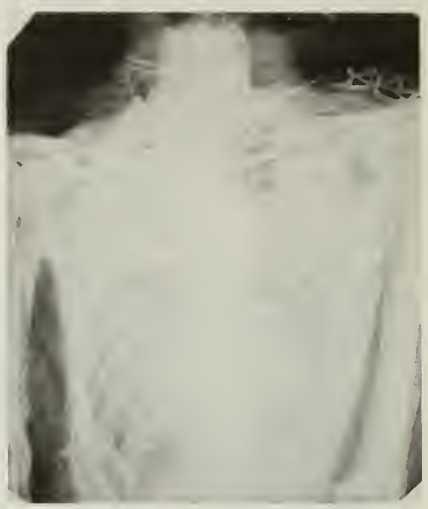
** A review of Dr. Mack's book, by Guillermo C. Sanchez '49, appeared in the January/February* HMAB.

Bulletin Bazaar

Buy, sell or swap? This is just a reminder that space is available in every issue of the HMAB to communicate your offers or desires to 12,000 potential respondents. For our reasonable rates, please refer to page 2 of the March/April 1977 issue. The deadline for inclusion in the September/October issue is August 1.

OFF WITH HIS HEAD!

Our printer undoubtedly thought it of no consequence to slice off the top of the Ether Dome mummy's chest x-ray, pictured on page 10 of the March/April Bulletin. *But the case of the Ether Dome mummy rests on those few millimeters of empty space, which are crucial evidence for a certain inexplicable fact: that the head of the mummy is not attached to his neck!*



Radiologist Jack Dreyfuss had pointed out — as should be more clearly visible here — that at some time during the twenty-six centuries of Paddy Hershef's existence as a mummy, his 1st through 4th and most of his 5th cervical vertebrae mysteriously parted ways with the remainder of his remains. The x-rays, however, will be preserved. Dr. Dreyfuss recently presented them to the Countway Library, where they will reside in perpetuity.

Internship List

Abkowitz, Janis L.
Beth Israel Hospital
Internal Medicine

Albino, Juan A.
Montefiore Hospital Center
Social Medicine

Albert, Thomas W.
Massachusetts General Hospital
Oral Surgery

Alcala, Daniel H.
Los Angeles County-USC Center
Internal Medicine

Aretz, Thomas H.
Massachusetts General Hospital
Pathology

Audet, James P.
H. C. Moffitt Hospital
San Francisco,
Medicine

Averill, Mary C.
University of Virginia Hospitals
Charlottesville,
Internal Medicine

Ballinger, Jeanne F.
Vanderbilt University Affiliated Hospital,
Nashville, *Surgery*

Barbieri, Robert
Peter Bent Brigham Hospital
Internal Medicine

Bassil, Barbara
Massachusetts General Hospital
Surgery

Baumann, John C.
Walter Reed Army Hospital
Washington, D.C., *Medicine*

Bedell, Susanna E.
Beth Israel Hospital
Internal Medicine

Bell, David M.
Children's Hospital Medical Center
Pediatrics

Berkelman, Ruth L.
Cambridge Hospital
Internal Medicine

Berman, Ellin
University Hospital
Boston, *Medicine*

Bertozzi, Carole J.
Beth Israel Hospital
Internal Medicine

Birdwell, Robyn L.
Peter Bent Brigham Hospital
Internal Medicine

Blackshear, Perry J.
Massachusetts General Hospital
Internal Medicine

Bloomingdale, Kerry L.
Massachusetts Mental Health Center
Psychiatry

Bookhout, Lynne C.
Mary Imogene Bassett Hospital
Cooperstown, New York,
Internal Medicine

Brill, Judith E.
Children's Hospital Medical Center
Pediatrics

Britt, Lunzy D.
Washington University Affiliated Hospitals
Barnes Hospital
Surgery

Brodsky, Gilbert L.
Massachusetts General Hospital
Pathology

Burstein, David E.
Mount Auburn Hospital
Internal Medicine

Bursztajn, Harold
Children's Hospital Medical Center
Pediatrics

Cardi, Michael A.
Beth Israel Hospital
Internal Medicine

Carson, Lesley S.
Mount Auburn Hospital
Internal Medicine

Carter, Janice H.
University of California Hospitals
San Francisco, *Flexible (Pediatrics)*

Charow, Susan F.
Massachusetts Mental Health Center
Psychiatry

Cohen, David I.
Barnes Hospital Group
Internal Medicine

Cohen, Raphael M.
New England Medical Center Hospital
Internal Medicine

Collins, Marguerite H.
Mount Auburn Hospital
Internal Medicine

Conner, Edison S.
San Diego County University Hospital
Surgery

Conrad, Chester H.
Hospitals University Health Center
Pittsburgh, *Internal Medicine*

Cook, Patricia A.
Mount Auburn Hospital
Internal Medicine

Cousins, Amy R.
Roosevelt Hospital
New York, *Surgery*

Crane, Ruth J.
Peter Bent Brigham Hospital
Surgery

Crawford, John L., 2nd
Massachusetts General Hospital
Surgery

Eisenberg, Frank
University of Maryland Hospital
Baltimore, *Family Practice*

Embick, Andrew R.
Beth Israel Hospital
Surgery

Ervin, Lauri D.
New England Medical Center Hospital
Pediatrics

Eyler, Steven W.
Los Angeles County Harbor General
Hospital
Internal Medicine

Falanga, Vincent
University of Miami Affiliated Hospitals,
Internal Medicine

Fenno, M. Joan
Massachusetts General Hospital
Pediatrics

Fischer, Robert A.
Los Angeles County-USC Center,
Internal Medicine

Flowers, James L.
Mount Sinai Medical Center
Milwaukee, *Internal Medicine*

Fogelson, David L.
Faulkner Hospital
Internal Medicine

Foggs, Michael B.
Northwestern University Medical School
Internal Medicine

Gage, John S.
Beth Israel Hospital
Surgery

Gallegos, Karl V.
Roosevelt Hospital
New York, *Surgery*

Ganem, Donald E.
Peter Bent Brigham Hospital
Internal Medicine

Garcia, Sandra
San Francisco General Hospital
Flexible (Pediatrics)

Garewal, Harinder S.
University of Oregon Hospitals
Portland, *Internal Medicine*

Gaz, Randall D.
Massachusetts General Hospital
Surgery

Gerson, Stanton L.
Hospital of the University of Pennsylvania,
Internal Medicine

Gilbert, Charles D.
Department of Neurobiology
Harvard Medical School, *Research*

Glowa, Patricia T.
Highland Hospital
Rochester, *Family Practice*

Glueck, Robert M.
University of Texas SW Affiliated Hospitals,
Dallas, *Internal Medicine*

Goldsmith, Marianne G.
Children's Hospital Medical Center
Pediatrics

Granich, Mark S.
New England Deaconess Hospital
Surgery

Gray, Richard N.
Los Angeles County-USC Center,
Internal Medicine

Green, Robert P.
Mount Sinai Hospital
New York, *Surgery*

Greenberg, Leslie M.
Beth Israel Hospital
Surgery

Griffin, Marilyn P.
Peter Bent Brigham Hospital
Internal Medicine

Grossman, Richard S.
Massachusetts General Hospital
Internal Medicine

Hagen, Allen P-V
Newton-Wellesley Hospital
Internal Medicine

Hall, Joseph E., Jr.
Boston City Hospital
Pediatrics

Hall, Robert E.
Case Western Reserve University Hospital
Internal Medicine

Hardy, Julia A.
University of Texas SW Affiliated Hospitals,
Dallas, *Internal Medicine*

Hartley, Robert M.
Peter Bent Brigham Hospital
Internal Medicine

Hecht, Gary M.
NYU-Bellevue Hospital
Internal Medicine

Heifetz, Ronnie L.
Downstate Medical Center
Brooklyn, *Medicine*

Herman, Jay H.
Grady Memorial Hospital
Atlanta, *Pediatrics*

Hettleman, Bruce D.
Duke University Medical Center
Internal Medicine

Hochman, Judith S.
Peter Bent Brigham Hospital
Internal Medicine

Hubbard, Richard C.
Mount Sinai Hospital
New York, *Internal Medicine*

Jantzen, Ellen C.
Stanford University
Pediatrics

Jenkins, Jon L.
Peter Bent Brigham Hospital
Internal Medicine

Joseph, Massad G.
Good Samaritan Hospital
Los Angeles, *Internal Medicine*

Kanter, Craig M.
Northwestern University Medical School
Internal Medicine

Kaplan, Michael J.
Beth Israel Hospital
Surgery

Karaian, Charles H.
University of Oregon Hospitals and Clinics
Portland, *Internal Medicine*

Kirsch, Ilan R.
Children's Hospital Medical Center
Pediatrics

Klausner, Mark A.
Presbyterian Hospital
New York, *Internal Medicine*

Klitzner, Barry M.
Roger Williams General Hospital
Providence, *Internal Medicine*

Koch, Douglas D.
Baylor College Affiliated Hospitals
Houston, *Internal Medicine*

Kramer, Karen L.
Michael Reese Hospital
Chicago, *Obstetrics and Gynecology*

Krotzer, Steven S.
Roosevelt Hospital
New York, *Internal Medicine*

Krueger, Richard B.
Veterans Administration Hospital
Internal Medicine

Leichtner, Alan M.
Children's Hospital Medical Center
Pediatrics

Levine, Ira C.
Massachusetts General Hospital
Surgery

Levine, Jedd F.
Beth Israel Hospital
Internal Medicine

Levine, Mark A.
Johns Hopkins Hospital
Baltimore, *Internal Medicine*

Levitan, Deborah A.
Hospital of the University of Pennsylvania
Obstetrics and Gynecology

Liang, Gwen J.
New England Deaconess Hospital
Internal Medicine

Loh, Dennis Y-D
Peter Bent Brigham Hospital
Internal Medicine

Lonergan, Francis R.
Medical Center Hospitals
Charleston, South Carolina,
Family Practice

Louie, Eric K.
Peter Bent Brigham Hospital
Internal Medicine

Lucas, Stephen K.
Duke University Medical Center
Internal Medicine

Ma, Yeou-Cheng M.
NYU Medical Center
Pediatrics

Margulies, David M.
Downstate Medical Center
Brooklyn, *Internal Medicine*

McAuley, Bruce J.
University of California Hospitals
San Francisco, *Internal Medicine*

Merriam, John C.
New England Deaconess Hospital
Surgery

Metz, Werner P.
Children's Center University Hospital
Seattle, *Pediatrics*

Michaels, Robert S.
Children's Hospital Medical Center
Pediatrics

Miller, Richard A.
Massachusetts General Hospital
Internal Medicine

Moreno, Carlos A.
University of San Antonio Teaching Hospital
Family Medicine

Moreta, Henry G.
North Shore University Hospital
Manhasset, New York, *Internal Medicine*

Myers, Debra J.
Stanford University
Internal Medicine

Myers, Woodrow A. Jr.
Stanford University
Internal Medicine

Myers, John A.
St. Vincent's Hospital
Worcester, *Pediatrics*

Nussbaum, Alan I.
Duke University Medical Center
Internal Medicine

O'Brien, Mary E.
Presbyterian Hospital
New York, *Internal Medicine*

Ofman, David
University of Washington Affiliated Hospitals,
Seattle, *Internal Medicine*

Paccione, Gerald A., Jr.
Presbyterian Hospital
New York, *Internal Medicine*

Pacheco, Jose P.
University of Colorado Affiliated Hospitals
Denver, *Internal Medicine*

Payne, Richard
Peter Bent Brigham Hospital
Internal Medicine

Pine, Janet H.
Hennepin County General Hospital
Minneapolis, *Internal Medicine*

Pittman, Phillip R.
Presbyterian Hospital
New York, *Internal Medicine*

Pollack, Phyllis
Children's Center University Hospital
Seattle, *Pediatrics*

Powelson, Stephen W.
NYU-Bellevue Hospital
Internal Medicine

Raymond, Laurie W.
Massachusetts General Hospital
Internal Medicine

Rich, Daniel S.
Roosevelt Hospital
New York, *Surgery*

Roberts, Douglas G.
Michael Reese Hospital Chicago
Internal Medicine

Ross, Douglas S.
Massachusetts General Hospital
Internal Medicine

Rudinger, Ann N.
Edward J. Meyer Memorial Hospital
Internal Medicine

Ryan, Charles L., 3rd
Massachusetts General Hospital
Pediatrics

Sarokhan, Alan J.
Peter Bent Brigham Hospital
Surgery

Sarokhan, Carol D.
Peter Bent Brigham Hospital
Medicine

Schneller, Stanley J.
Presbyterian Hospital
New York, *Internal Medicine*

Schreiner, George F.
Peter Bent Brigham Hospital
Internal Medicine

Seidlin, Mindell
Mount Sinai Hospital
New York, *Internal Medicine*

Seltzer, Terry F.
NYU-Bellevue Hospital
Internal Medicine

Shellito, Paul C.
Massachusetts General Hospital
Surgery

Shulman, Lisa
Virginia Mason Hospital
Seattle, *Internal Medicine*

Siliski, John M.
Massachusetts General Hospital
Surgery

Singer, Karen R.
Roosevelt Hospital
New York, *Surgery*

Snyder, David S.
Presbyterian Hospital
New York, *Internal Medicine*

Sondel, Paul M.
University of Minnesota Hospitals
Minneapolis, *Pediatrics*

Spunberg, Jerome J.
Lenox Hill Hospital
New York, *Internal Medicine*

Steinbock, Robert T.
Massachusetts General Hospital
Internal Medicine

Steinert, Roger F.
Newton-Wellesley Hospital
Internal Medicine

Steinhaus, David M.
Massachusetts General Hospital
Internal Medicine

Sugarman, Lynn M.B.
Bronx-Municipal Hospital Center
Pediatrics

Sussman, Elliot J.
Hospital of the University of Pennsylvania
Internal Medicine

Swerdlow, Paul S.
University of Michigan Affiliated Hospitals
Ann Arbor, *Internal Medicine*

Taylor, Robert G.
Veterans Administration Hospital
Internal Medicine

Theard, Joycelyn M.
University of Texas SW Affiliated Hospitals,
Dallas, *Internal Medicine*

Thompson, Stephen D.
University of Colorado Affiliated Hospitals
Denver, *Pediatrics*

Thurlow, Peter M.
Duke University Medical Center
Surgery

Tosi, Laura L.
Presbyterian Hospital
New York, *Internal Medicine*

Valgamae, Allan H.
Cambridge Hospital
Psychiatry

Viccellio, Asa W., 3rd
NYU-Bellevue Hospital
Internal Medicine

von Reuden, Richard A.
Children's Mercy Hospital
Kansas City, Missouri, *Pediatrics*

Weiss, Gary D.
Peter Bent Brigham Hospital
Surgery

Wheeler, Rachel
St Vincent's Hospital
Worcester, *Family Practice*

Williams, James H., Jr.
Georgetown University Hospital
Washington, D.C., *Internal Medicine*

Willis, Alphonso
Letterman Army Medical Center
San Francisco, *Medicine*

Willis, Ernestine
Cleveland Metropolitan General Hospital
Pediatrics

Wilson, Claire D.
Children's Hospital Medical Center
Pediatrics

Wilson, Richard W.
University of Utah Affiliated Hospitals
Salt Lake City, *Pediatrics*

Woodbury-Farina, Camille M.
Municipal Hospital Medical Center
University of Puerto Rico, *Pediatrics*

Woods, Gary A.
University Hospital
Little Rock, Arkansas, *Family Practice*

Worthen, George S.
Beth Israel Hospital
Internal Medicine

Wright, Richard F.
Los Angeles County - USC Center
Internal Medicine

Wright, Thomas C., Jr.
Department of Pathology
Harvard Medical School, *Research*

Yavitz, Edward Q.
Newton-Wellesley Hospital
Internal Medicine

Zaleznik, Doris F.
Beth Israel Hospital
Internal Medicine

Zaslow, Michael C.
Temple University Hospital
Philadelphia, *Internal Medicine*

Cramalot

by Tim Reynolds

Drama lives in every classroom at Harvard Medical School. Even the architecture conforms to it with the podium, the rising tiers of student spectators, and the implications of "amphitheatre" evoking echoes of a Greek arena. The actors use an expensive array of props to create their effects: blackboards, colored chalk, colored slides, motion pictures and sound amplification systems. The attentive audience has its own impromptu dramatic moments, although the plot never reaches a climax and the emotions aroused often find no release.

A stage play, on the other hand, should have a cathartic effect, confronting the spectators with concrete projections of their deepest fears and anxieties, formerly experienced only half consciously. As Antonin Artaud describes theatre: "A real stage play disturbs our peace of mind, releases our repressed subconscious and drives us to potential rebellion. . . ."

The Harvard Medical School, in support of rebellious spirits, affords its students the opportunity to vent their zealous opinions and observations on a stage and in a mode sanctioned for just such commentaries. This opportunity is annually accepted to display, in song and dance, an individual class's interpretation of the ultimate realities of HMS. There is nothing yet devised at this medical school that serves so well to momentarily allay the tensions and barely controlled hostilities that build up between students and faculty, and particularly among classmates.

Tim Reynolds was the director and general factotum of the second year show.

On the evenings of February 10, 11 and 12 in the Vanderbilt Hall gymnasium the Class of 1979 presented a theatrical escapade affectionately known as *Cramalot: the once and future dean.* The title reveals in a word both the plight of the Harvard Medical student and the source of our stolen plot. I shall not pretend to hide the fact that this drama was hailed as a masterpiece by performers and audience alike. Yet one could not think of it as a masterpiece in the Aristotelian sense, as a great tragedy or comedy. In that tradition disastrous events were deemed tragedies and ridiculous ones, comedies. Anyone who attended our presentation found it difficult to distinguish the disastrous moments from the ridiculous.

Cramalot was not the product of a single wag. The task of writing the script fell on seventeen of us. In October 1976, we made a plea to the entire class for original songs and for new lyrics to time-tested melodies. By Thanksgiving we had about fifteen songs from a motley group of writers —more like reviewers at that point —who met weekly to search for the merits in the lyrical compositions, to materialize a plot from a sea of random ideas and characters, and to remind ourselves of how witty we all were. Characters were easily conceived in song and scene but continuity eluded us. We felt oppressed by the prospect of having a delightful character without a play to place him in. In class we traded whispered snatches of plot, testing new ideas on friends and trying to spark one another's latent creativity. I was reminded of the hauntingly amusing preface to *Six Characters in Search of an Author* wherein Pirandello describes his plight in conceiving the play: ". . . while I persisted in desiring to drive the characters out of my spirit, they, as if . . . characters from a novel miraculously emerging from the pages of the book that contained them, went on living on their own, choosing certain moments of the day to reappear before me in the solitude of my study and coming . . . to tempt me to propose that I present this scene or that. . . ."

Christmas vacation ended, our rehearsals were scheduled to begin January 10, and still there was no script to rehearse. The writers now conferred in two separate caucuses, each both creating new material and rejecting contributions of the other. The editing that resulted was not always warmly received.

Appearing in a cameo role, Dean Ebert perorates while Tim Reynolds, as the wizard Merlin, sings.

"Back at the start of my term,
when men were men
and women were girls . . .
when men were men
and women were grateful . . .

. . . the once and future dean

In these workshops we experimented with a new genre — *theatre of situation*, in which each scene stood independently of the others, with its own characters and set of circumstances — also known as the "amateur hour" format. Nevertheless, some conservatives in our group felt that we needed a plot, and devised a scenario — a contest to choose a dean for HMS. It was implicitly agreed that we could not rely on this plot for entertainment.

A journal of our hectic production month, January 1977, would read as follows.

Above: Marguerite Barnett passes out the Benson & Hedges "cigarettes," Dr. Benson's transcendental cure for hypertension. Below: Monz Pubis (Kim Atwood), leader of the Grubs.

"When I first got interested in this drug, I was a lonely, uptight cardiologist doing research on the length-tension curve of cat papillary muscles."

"When you're a Grub
Pathophys is a breeze
From your first parasite
To your last weird disease.

When you're a Grub
To brownnose
is the style
Leap up after class
Talk with the prof
for a while."

— to the tune of "The Jet Song" from West Side Story

The *Cramalot* script was not entirely ready for our first rehearsal. (If it had been there would have been cause for concern.) This meant that at the script read-throughs in front of the entire class I could minimize any violent reactions only by being sufficiently vague about content. I stood before a critical crowd reading from the so-called script, sketching scenes on a blackboard, performing objectionable choreography and ultimately making a perfect fool of myself — something which I delight in doing. When most of the show had been cast, we embarked on a grueling rehearsal schedule.

Most rehearsals were conducted in the Vanderbilt Hall common room, where we romped through the scenes on stuffed chairs and long tables; the oriental rug provided ideal markings for

Carol Vasconcellos leads a lusty tango to the tune of "Hernando's Hideaway."

"There is a dark
secluded place
Above the knees,
Below the waist
Where brave men dare not
show their face —
It's called Anne Barnes's
Hideaway — Olé!"

"The Monz" and Sarah Tonin (Nancy Bennet)

"Work, we must do work!
There are billions of facts
we must know when
we're doctors.

Terms, so many terms.
We must learn them today,
so we'll know them
on Monday."

blocking. Singing was stressed from the beginning, especially since most of the cast boasted of being tone-deaf and could only be coaxed into chorus participation. We learned that whereas walking and chewing gum are simple tasks to accomplish together, singing and dancing require complex cognitive skills for simultaneous performance. (The expression "foot in mouth" surely alludes to the mutual exclusivity of these activities.) However, all such obstacles were gradually overcome. We rehearsed five nights per week and additional mornings and afternoons for two weeks, then disbanded when the presemester vacation arrived. Our seven piece orchestra rehearsed weekly. Their progress was hardly accelerated by the repeated changes of vocal key insisted on by the cast; and rehearsing the groups separately forestalled the inevitable clash. After January we reluctantly left our oriental rug and moved to the big stage in the gym.

The generous financial support of Harvard Medical School enabled us to build our stage and set from scratch. Without the unwavering optimism of Mr. Richard Olendzki, associate dean for financial affairs, who procured the wherewithal, and the tireless efforts of Mr. John Cataldo of buildings and grounds, our labors would have been much more arduous. The stage is now available for future productions, along with the Aesculapian Club's gift of lighting equipment which should hereafter relieve posterity of great financial burdens. For *Cramalot* our set was minimal — a dozen plywood cubes painted in bright colors, which were quickly arranged into anything from a stretcher to amphitheatre seats.

Stage, lights, paint, set and properties were in place in Vanderbilt Hall gym upon our return from presemester break on Sunday, February 6. This was the rehearsal I had been dreading since October: Bloody Sunday. We would rehearse with cast and orchestra together for the first time. A conspicuous absence of microphones for the cast and a conspicuous abundance of microphones in the orchestra on this occasion mercifully prevented cast members from hearing one another; this was the start of a protracted showdown between cast and orchestra.

We cringed at scenes which had run so smoothly on the oriental rug. We groaned at performances which may have harbored some element of life, but if so were now certainly not life "as we know it." We repeated scenes again and again. We rehearsed the finale for the first time, with our title song, "Cramalot." The finale extravaganza pointed out one thing to the entire company: it is difficult to coordinate sixty people on a sixteen by twenty-four foot stage.

We strove to develop a consistency to our performances. Instead, what developed was a consistency of entertainment, achieved through a variety of performance styles. In certain scenes cast members never knew what to expect from their fellow performers — and often neither did the performers themselves. We were faithful to the adage of the acting profession: "If you must do something wrong, do it well." Gradually, we all attained an inflated confidence in our performances, which gave rise to unrestrained extemporizing on stage. We began weaving small command

Left: Dr. Chromocytoma (Mike Hirsh) sings a ballad of Pheochromocytoma. Right: A student (Jim Kirshenbaum) questions the "social relevance of disease."

"Mr. Jensen, I have two closely related questions. First, did you love your mother? And second, do you feel your death was justified after multiple resuscitations at a tremendous cost to society?"

"I hoped I could save the one dude in a million with pheo."

performances into nightly routines. Like the true script, these were only variably appreciated by the audiences, but always provoked uncontrolled guffaws from the cast.

At last we were all together — cast, orchestra and stage crew — and we watched each other's performances eagerly and critically. We laughed and applauded even our colleagues' most abortive punch lines. We performed for an audience of our peers and were finally received into a group we thought we had already belonged to. The final week of rehearsals and performances transformed the atmosphere that had erstwhile surrounded the players of *Cramalot.* A letter I received shortly after the show describes the spirit in a style I cannot duplicate. ". . . A funny thing happened, and that was the perception that we were all working to accomplish a common goal. Instead of being thrown together by fate and just making do, I felt a surge of intimacy with many, many people in the class. They were no longer just faces in amphitheatre E. . . . This intimacy peaked on opening night and kept on peaking! It was glorious!"

The finale

"Once upon a time
we were idealistic,
But at prestige and wealth
we'll no more sneer.
In short, there just is not
a more congenial spot
For starting on a status-
filled career than Cramalot."

We talked a lot of the importance of these experiences, often as though we wanted the show to last for another week or longer. Why do we so often grasp for permanence in something that can only be evanescent? We danced together, sang together, laughed together. We shared fear, fatigue, anxiety, anticipation and joy. We had become a cohesive and responsive company. Now the passage of time has separated us from all these experiences. The one tangible sentiment we all retain from the *Cramalot* experience is friendship. I trust that will not fade quickly.

Making a good match

by Curtis Prout

After at least two decades of competing for ever loftier attainments against increasingly able competition, our fourth year medical students spend two-thirds of their last year at HMS in anxious anticipation of the first plum of their postgraduate lives — their internship. The competition from grade school through medical school tends to produce a breed of achievers — sometimes even against their will. Under incessant pressure to breach the next hurdle, it is naturally difficult for young men and women to make a coherent long-range life plan, although this is exactly what we, their medical elders, peremptorily ask them to do in selecting first, a career within the field of medicine, and second, the appropriate type of internship.

Of the 170 members of the class of 1977, 163 applied to the National Internship and Residency Matching Plan (NIRMP). Included among the nine students who did not go through the plan were some who went through a "Special Arrangement Plan for Engaged or Married Students" set up by the NIRMP. Two students received military internships as part of a pre-arranged scholarship package. Eight did not match on the first round (in most cases this was because their applications in an intensely competitive field did not include any other than the very top hospitals.) A few did not match immediately because they applied as couples. A look at the list of students (see p. 4) and the first year internship positions to which they are matched shows that all of them did well. There seems to be little change in recent years in the successful quest by HMS students: seventy-one of the 163 placed in the hospital of their first choice; twenty-two in their second choice; thirteen in their third; and seventeen in their fourth choice.

The tendency of students from Harvard, as well as from other east coast medical schools, either to stay on the east coast or to move to the west coast, continues to increase. West coast students behave in parallel fashion. The converse, incidentally, is equally true; that is, students from midwestern colleges tend to go to midwestern medical schools now, and from midwestern medical schools to midwestern internship programs. The reasons for this trend are partly economic, but also partly unexplained.

One of the most useful sources of information for our students is a series of thoughtful replies to a questionnaire which has been sent out to HMS alumni during their first, second or third year of residency training. This has been the practice since 1969, when Dr. Joseph Gardella, who perfected the art of writing the Dean's letter, was the dean of students. These comments are available in my office and the students study them diligently. In general, our young graduates are candid and fair. They are quick to differentiate between excessively routine "scut" work and hard work done under careful supervision with frequent conferences. As ever, there is a delicate balance between the wishes of the private physician, or the powerful ward visit, and the needs of the house officer to be given responsibility. This is obviously an unresolved problem and will continue to be so. In some hospitals, the feedback tells us, women are not yet really accepted or expected. The most pointed symbols of this foot-dragging by the dominant male are the absence of separate toilet facilities and inadequate provisions for sleeping quarters.

Over the years a solid third of the graduating class has continued in the Boston area, usually at Harvard teaching hospitals. Most students, given a chance, would choose to stay in Boston — this is verified by the large numbers who deluge the local institutional pantheon with applications. In retrospect, of those who leave disheartened about breaking the HMS umbilical cord for more than a year, many come to appreciate the perspective that physical distance gives. Several students who fatalistically headed for Dallas became enamored of both the city and their hospital training. An alumnus who graduated a couple of years ago wrote: "With a little luck, I have done far better than the average intern at MGH, and at least as well as the luckier ones. I put this hospital second to MGH on my preference list. If I had it to do over again, I might well put it first. In other words, I'm fully satisfied to be here." A slightly older graduate seconded this positive reaction. "Dallas itself is really ok . . . less conservative than I expected. I think this is an excellent internship, mainly because of the superb medicine staff . . . and offers a nice (and stimulating) contrast to the 'Harvard Doctrine' (by no means the last word, to be sure)." It would seem that the HMS faculty espouses a parochial view of the

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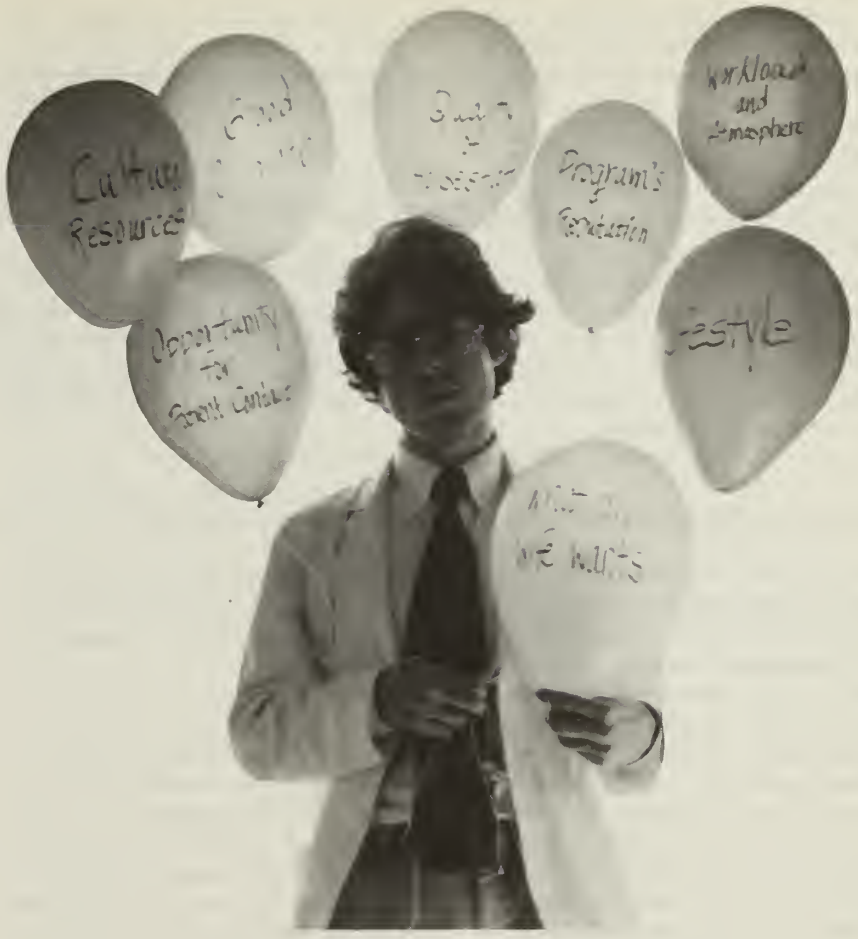
Last spring, Dean Ebert entrusted Dr. Curtis Prout '41 with the responsibility for internship advising. In that capacity, Dr. Prout authored the "Dean's letters" for the Class of 1977. He reflects on the problems and results of the matching process.



world. The longer our graduates stay away, the more sardonic their references to Mecca.

The rollercoaster of specialty choice reflects the ostensible needs of society, and theoretically a natural balance is effected, which precludes a surfeit of any one specialty. In recent years the federal government has become the custodian of this ideal, acting as both the brake and accelerator of the rollercoaster. Through the early 1940s, surgery was the coveted specialty; by 1945 internal medicine had been catapulted to the number one spot. Interestingly enough, ten to fifteen years ago, there was a period when the largest contingent of HMS students sought psychiatry internships. Shall we proselytize for those specialties which lack applicants? Although I was apprehensive at first that the students' preparation was incompatible with the kinds and numbers of good internships that they sought, I now know that our students can make the adjustment. The overall ratio of HMS students accepted at the Harvard hospitals this year to those who applied reaffirms our intuition that HMS's graduates are as good as ever.

As it always does, the pendulum has swung back in the last couple of years to where internal medicine again leads the list. The totals are somewhat deceiving, however, since all 105 internal medicine interns will not end up in general internal medicine; many will funnel through to psychiatry, ophthalmology, family practice and radiology after a year or two. Altogether there are 1100 first year postgraduate positions at Harvard's teaching hospitals alone, encompassing the primary care specialties — internal medicine, general pediatrics and obstetrics/gynecology, and nineteen other specialized areas. A general first year is strongly recommended and even required for almost all of the more specialized programs. For example, the American Board of Psychiatry and Neurology, which for a time did not require a medical internship, has since reinstated this as a requirement. Many ophthalmology programs which used to require surgical training, now accept medical training instead, and some even prefer it.

The number of students applying to family practice internships dropped sharply from last year, but on talking with them it is quite evident that this is because students perceive these internships as being inferior in quality to those in internal medicine. One noteworthy exception, according to several recent graduates, is the program of the Medical University of South Carolina Hospitals. One house officer lauded it as "the only university based program I visited in which family practice was not a second class specialty." Several students plan to train in medicine and ultimately to end up in family practice or primary care-internal medicine.

One surprise statistic emerged during the year — seventeen students (ten per cent of the class) want to become ophthalmologists. I discussed this phenomenon with Dr. Edward Maumenee, the chief of ophthalmology at Johns Hopkins, among others; we are all in accord that this is part of a national pattern. The motivation in most cases seems to be that ophthalmology affords a good living, regular hours, good status, and is intellectually "respectable." Some students frankly said that ophthalmology was not their most burning medical interest, but it offered an attractive life-style.

It has been part of my eminent domain to author the "Dean's letter." This is the only official statement made by any medical school about a student. It serves several purposes, and must be approached with caution by writer and reader. Certainly the letter should be sufficiently informative, in conjunction with the other parts of the application, to help the hospital selection committee form a clear picture of the student from as many different perspectives as possible. The letter must also not contain untruths, nor totally ignore a student's

"Human nature being what it is, in the absence of grades everyone scans the letter looking for a 'key word'."

problems or liabilities. Unfortunately the selection committees often look closely for any word or phrase which might result in immediate elimination from competition. If one instructor makes a derogatory comment when all the other comments are favorable, should that be quoted verbatim? The student, understandably anxious to press for every advantage, is often abrasive and demanding to the secretarial and administrative staff; should such behavior be mentioned as part of the evaluation? (This year we were charitable.) Again, we can describe a person who will surely become a brilliant contributor to academic medicine, but to what extent should we also say that he or she will probably not be liked by his or her patients or colleagues? Inference and elision have their uses, but even these can be double-edged.

Since the hospital considering the student can obtain academic transcripts with written permission of the student, my conception of the Dean's letter is to describe the student as fully and as honestly as possible. We do this by using the extensive material available from the student's record in the registrar's office, which covers all activity from the day of admission, and many of the pertinent data from the admission office, too. This is rounded out by interviews with the student, and by communicating with the student's instructors and/or research supervisor. Further information and selected direct comments from the student's major clerkship instructors go into the brew. The candor and completeness of the reports from the clerkships is sometimes less than might be desired, but it is very clear that all of our teaching hospitals spend a great deal of time, thought and care in evaluating the students and attempting to describe them fairly and completely.

The law contributes to a lack of specificity in the Dean's letter. We cannot mention sex, race, religion, type of minority or physical appearance. Under the Buckley Amendment, the student has the right to see any materials in his or her folder, and last year we obliged by sharing the content of the letter before it was completed. This experiment of discussing the letter and sometimes negotiating its semantics has proven impractical and undesirable. We cannot have advisors, friends, parents, or attorneys participate in the construction of the letter. Again this year we are asking each student to write an autobiographical statement of his or her strong points, assets and hopes for the future. Last year this helped me immeasurably, as the students know that we are aware of their qualities and thus can argue their merits more effectively.

From the point of view of the hospital making the selection, it seems there are two serious deficiencies in the letters from HMS. At present, we have no grading system, merely "unsatisfactory," "satisfactory," or "excellent." Obviously there can be no class ranking under such a system, and this prevents the hospital from making a quick comparative rating. Human nature being what it is, in the absence of grades everyone scans the letter looking for a "key word." It is a general assumption that the rating of "Excellent," means a grade of "A," yet this assumption not only cannot be substantiated, but runs counter to the students' expressed desire to omit grades altogether. In reading all of this prolix material, most hospital personnel suspend judgment until they reach the final sentence in which, they fervently hope, lies a secret code word, such as "excellent," "outstanding," or "very good."

To give this rating on the basis of purely objective criteria would shortchange both the hospital and the student; in the last analysis it must be a subjective judgment, it seems to me. However, not to have such an indication when discriminating among hundreds of seemingly equally endowed young physicians makes rapid screening difficult. From where I sit, it is indescribably hard to find 163 synonyms for "good," let alone conjure up 163 gradations of virtue.

Many of the best hospital programs — particularly in medicine — receive five hundred or more applications. From the manner in which a number of students this year rather promptly received the word that they were not under consideration, or that they would not be interviewed, it was apparent that rapid preliminary screening was taking place. Sometimes this screening appeared to have been carried out at a clerical level. The chief of one major hospital in New York acknowledged, after my protestations, that he had gone through the reject pile and resurrected many of our candidates; indeed, several are now going to intern at his hospital.

If our Dean's letter is to be a painstakingly thorough appraisal of the personal characteristics, mode of life, and achievements of the applicant, with unabridged quotations from clerkship and

research supervisors, it becomes a two or three-page letter, which under the pressure of numbers is often not going to be read in its entirety. This coming year the letter somehow will be shorter and will omit all ratings, leaving the hospitals to request the student to forward the necessary transcripts, if so desired.

The timing of the Dean's letter is proving more nettlesome every year. Many hospitals unequivocally state that they simply will not interview a candidate until the Dean's letter is in hand, and furthermore, they insist on seeing the candidate early. Therefore, many students who plan to combine a summer vacation with a visit to various hospitals will ask for their letter by July or August following the third year. Inevitably then, the letter tends to be based on incomplete clinical evaluations. It is really to the advantage of the student to defer the letter until the major clerkship evaluations have been recorded. Worse yet, positions in psychiatry, ophthalmology, dermatology and orthopedics, to name a few, are now awarded over a year in advance. This calls on the School to produce a letter with insufficient data, and requires the student to make a precise career choice two years in advance of the internship itself.

The only people who represent the power structure in both the medical school and the teaching hospitals are the professors of medicine and surgery. I hope that within the near future, the right hand will meet the left hand, and decide on a reasonable timing for mailing the letter.

As we all know, scuttlebutt plays an inordinately large role in the selection of internship and residency training. Those of us who are the students' internship advisors must be, among other things, connoisseurs of rumors. I spent long hours helping students wade through nebulous factors. Many rule out excellent municipal or county hospitals because of hearsay (often correct) of impending financial cutbacks in training programs. When reports of prejudices against women or of anticipated shake-ups in a hospital department circulate through the HMS grapevine, it is as though a plague had been visited on the institution in question. Interns-to-be also eschew certain programs because of what they deem to be excessive disruption of their personal lives — even for internship. One of the finest programs, for example, has been avoided by most of our students because the interns are on duty every other night. Another criticism of some of the outstanding programs is that the interns must spend some time on the private service and have allegedly insufficient autonomy in managing their cases. Students avoid certain cities, particularly those having histories of riots and racial tensions. The recent severe winter also has made more students understandably interested in programs farther south and on the west coast.

One of my tasks as internship advisor is to talk with the student in ample detail to see that he or she is pursuing realistic choices. This often involves getting to know the student fairly well. The wisdom of the admission committee, or its good luck, in selecting these fine people is a source of wonder. As I could not help becoming involved in the students' welfare and concerns, the role of advocate, rather than judge or critic, came naturally.

Sometimes these discussions involve intense personal problems, so that counseling and support enter into the procedure. An especially poignant situation arises from time to time in connection with the joint application of a married or engaged couple. Under the current system, they may apply together, assuring an internship in the same city, or sometimes even in the same hospital. Mathematically, of course, this greatly reduces the probability of successfully matching the preference of both students to that of the hospital, which is unlikely to rank both persons equally highly. The couple must decide where they want to live and the hospital at which each wants to work — necessitating frank discussion of priorities, of whose needs are greater, and, invariably, some painful compromises are made. Helping young couples thread their way through such a

complicated decision, with such high stakes, made me feel at times like a marriage counselor. When a choice seemed to rest between the "best" internship and the marital relationship, I usually put the marriage before the hospital during some tense and fragile interpersonal moments.

While fifty-two members of the class of 1977 are married, the educated guess of Ms. Noreen Koller, the registrar, is that no more than a dozen students are married to other medical students, either at Harvard or elsewhere. Many medical student spouses have careers outside of medicine, and for these couples too, the choice of internship may mean stressful educational and financial dislocations. I could only listen with empathy and try to offer a broader perspective to offset anxiety about their decision.

How and why does such a system of bridging the transition from medical school to hospital work as well as it seems to for the majority of our graduates? Partly because of the reputation of the Harvard Medical School. More importantly, because of the endless hours of time spent by the faculty members, tutors and internship advisors. The largest factor of all in this successful quest is the high calibre of the students themselves. The greatest satisfaction for me has been in getting to know each student. Through their bright and acute observations and reflections we can get some idea of how we fulfill our roles as teachers, how Harvard looks to our students, and some of their uninhibited feelings about the state of medicine.

With the almost endless richness of the teaching experiences available in their last year of medical school, it seems too bad that our students have to spend so much time agonizing over internship choices, traveling, calling, writing and cajoling — and in general, not profiting from what should be their best year in medical school. As a member of the class of 1975 perceptively concluded: "Encourage students to realize that while they *feel* pressured for time in medical school, the demands and pressures are still less than they will experience in residency and practice. *Enjoy* medical school, especially its contemplative aspects. Acquire solid journal reading habits — especially the habit of criticism . . . Don't be in such a hurry to take advanced this and that. You'll never have a chance again, except possibly on a fellowship or sabbatical, to take an ethics, history, or economics course, to take a reading elective, to take a tutorial type elective or public health course, and the like." Only after March, when the matching results are published, do we see the students as they really are, and would like to be — normal human beings who are confident, relaxed, still hardworking, yet relatively free of distractions — and taking advantage, for the last time, of the opportunity to study medicine with time to reflect on what Harvard has offered them and what they will take with them when they embark upon internship.

"HELPING YOUNG COUPLES THREAD THEIR WAY THROUGH SUCH A COMPLICATED DECISION, WITH SUCH HIGH STAKES, MADE ME FEEL AT TIMES LIKE A MARRIAGE COUNSELOR."

Down with the Dean's letter?

by Deborah W. Miller

The following individuals participated in the Bulletin's *survey of house officer selection. Vincent T. Andriole, M.D., professor of medicine, and chairman housestaff committee, Yale School of Medicine; Stephen Goldfinger, associate professor of medicine, Massachusetts General Hospital; Arnold S. Relman, M.D., chief of the medical service, Hospital of the University of Pennsylvania; K. Reemstma, department of medicine, Presbyterian Hospital, New York; Hibbard E. Williams, M.D., chief of the medical service, University of California, San Francisco; Marshall A. Wolf '63, assistant professor of medicine, Peter Bent Brigham Hospital; W. Gerald Austen '55, chief of surgical services, MGH; William B. McDermott '42, chief of the Harvard Surgical Service, New England Deaconess Hospital; Robert M. Zollinger '59, associate professor of surgery, University Hospitals of Cleveland; George D. Zuidema, M.D., surgeon in chief, The Johns Hopkins Hospital; Mary Ellen Avery, M.D., physician in chief, Children's Hospital Medical Center; J. St. Geme, M.D., pediatric service, Los Angeles County Harbor General Hospital; Samuel L. Katz '52, chairman of the department of pediatrics, Duke University Medical Center; Hiram B. Curry, M.D., chairman of the department of family practice, Medical University of South Carolina; Ronald C. Slabaugh, Ph.D., education director, department of family and community medicine, University of Arkansas College of Medicine; Donald F. Treat, M.D., associate director, family medicine program, Highland Hospital, Rochester; Richard Shader, M.D., director of training and education, Massachusetts Mental Health Center; Philip L. Isenberg '55, director of resident education, McLean Hospital; C. Stephen Foster, M.D., director, residency training program, Massachusetts Eye and Ear Infirmary.*

The procedure for internship selection sounds deceptively simple: the students rank their preferences and the hospitals do the same. But anyone on the hospital's side involved in postgraduate education knows that the steps along the way are exceedingly deliberate, complex, and even tedious. Many programs receive hundreds of applications for only two dozen places or so. How can they know whom to accept? They decide by multiple means. The Dean's letter is but one of many criteria available for narrowing the field.

Some discouraging words had been filtering back about the impact of the Dean's letter which, it appeared, might be widespread. The acid test, we concluded, would be to poll a small cohort of residency directors about the validity of the letter and the alternative evaluative techniques at their disposal. Our survey does not include a broad spectrum of hospitals, but we did solicit comments from several Harvard hospitals and others scattered around the country which, throughout the years, have been highly esteemed by our students. The sampling included programs in the specialties of medicine, surgery, pediatrics, and family medicine.

Curiously, the Dean's letter has not always been the designated function of a dean. As long as the internship has existed, hospital selection committees have required an authoritative statement from each medical school assessing individual students' academic and clinical performance during the first three years of the curriculum. Suspicious of a letter sanctioned by the administration, these committees only respected the judgment of one of their own. Dr. Chester M. Jones '20, clinical professor of medicine emeritus at HMS, was the last of a series of eminent elder statesmen who took on this responsibility during their retirement years. Because there was no faculty member of equivalent stature who was inclined to devote himself to work of such magnitude, the Dean of Students, Dr. Joseph Gardella, came to share the responsibility in the middle 1950s and by 1969, was writing the letter on his own. Dr. Gardella recalls that he "gathered as much hard, cold data as representative, and didn't exaggerate the students' strengths or weaknesses." For the past five years, the letter has had a succession of authors — first Dr. Fred Lane, dean of students, from 1973 to 1975, and then for a year, Dr. Jack Ewalt, senior associate dean for clinical affairs, inherited that function prior to the incumbency of Dr. Curtis Prout '41, assistant clinical professor of medicine.

There was an explicit ranking system in effect until 1972, when Dr. Gardella resigned. He used "parameters that had universal applications" particularly for the benefit of selection committees at hospitals beyond the Harvard axis. A system of thirds categorized the excellent, the good to very good, and the satisfactory, and each year a handful of students were ranked as "superior."

"Many residency directors have been perplexed by the ambiguity of the descriptive words used in the summary sentence."

The demise of a formal rating system based on class rank has been the fallout from the trend of the last eight years at Harvard eliminating grades or numerical equivalents — a development urged by students to try to deemphasize the inherent competitiveness of medical school. Innovations in the grading system have been causing the first ripples of criticism from hospital selection committees, but this situation exists to varying degrees at other schools. In 1973, the HMS faculty voted to institute a grading system of excellent/satisfactory/unsatisfactory for both the clinical and preclinical courses. The classes of 1974 through 1976 received a hodgepodge of these terms as well as letter grades, which, for a time, were optional in all electives. The class of 1977 has been most affected of all: it was the first to spend four years at HMS without receiving any letter grades.

In lieu of class rank or grades to determine academic standing, the most crucial part of the Dean's letter came to be the concluding sentence, which, in the days of a standardized classification, simply said, for example, "I consider _____ an excellent candidate." There was instant comprehension on the part of the selection committee. In the last couple of years, many residency directors have been perplexed by the ambiguity of the descriptive words used in the summary sentence of the letter, and its meaning is no longer transparent. "At the least," laments Dr. Donald F. Treat, associate director of Highland Hospital's family medicine program in Rochester, "we ought to know what adjectives are being employed. After all, an 'excellent,' doesn't look nearly as promising when other students are being given 'superior,' 'outstanding,' or whatever."

A "Special Notice" appended to the 1977 letter, written by Dr. Prout, stated that "we feel that it is inappropriate to do other than to describe each student in terms of his or her own merit. . . Among our various teaching hospitals there is no consistency in regard to the number or percentage of students rated 'excellent.' " This disclaimer unsettled some program directors who before had felt a sense of security in the purpose and content of the summary sentence. Increasingly, they find themselves in a quandary, dubious about the value of the entire Dean's letter they receive from HMS. Yet, in this regard, one respondent commented, Harvard's letters are not significantly worse than those from other schools.

Dr. Samuel Katz '52, chairman of the pediatrics department at Duke University Medical Center, finds the tone too nebulous. "This past year's letters were even more 'vanilla' in their flavor. The graduates begin to have one shade of gray, with great difficulty in identifying the truly outstanding, the average, and the undistinguished. The Dean's letter has certainly lost much of its impact over the past several years." The absence of class rank and grades diminishes the import of the letter, agree a number of residency directors, and can even compromise a student's future graduate education. "There is simply no way of avoiding comparative evaluations of proficiency," asserts Dr. Arnold Relman, chief of medical services at the Hospital of the University of Pennsylvania. "That is the way our society works, and it is foolish to pretend otherwise."

Strong competition has made HMS students more aware that the pinnacle of excellence is being surmounted by students at other medical schools. Even though Dr. W. Gerald Austen '55, chief of the surgical services at the Massachusetts General Hospital, relies substantially on the letter, he cautions that substituting positive-sounding generalities can put an HMS applicant at risk. "If the Dean's letter at a good medical school states that the individual is ranked in the first five in the class and that information is compared with a vague statement from Harvard indicating that the student is excellent, it is really most difficult for the selection committee to equate these two letters."

Quite obviously, for HMS students applying to one of the teaching hospitals, performance in the clinical rotations is of paramount value. Students are exposed to programs to which they may later apply, and the hospital staff can form an impression of students' aptitude. The situation is equally true of other medical schools and their respective teaching hospitals. This does not mean that the Dean's letter is superfluous at such hospitals. Dr. Austen represents the viewpoint of a number of program directors when he comments that the letter is "one of the key matters of information that makes the decision concerning a particular student and his or her possible selection." Yet he concurs that "in general, the Dean's letter has, over the years, become progressively vague as the pressure from the students has made grades and crisp evaluation more and more difficult in course work." He suggests that for the Harvard hospitals, additional information could compare each candidate to the remainder of the class or to students applying to similar programs.

"Despite qualms about the Dean's letter, most comments attest to Harvard's high quotient of success in placing students in challenging postgraduate positions."

Some fault the letter for not revealing more overtly any defects that could cause serious problems in an internship. Dr. Marshall Wolf '63, assistant professor of medicine at the Peter Bent Brigham Hospital, acknowledges that there is a "strong negative selection factor" because "of those few individuals who have experienced difficulty with our program, approximately half have had some difficulty adjusting during medical school." When negative comments are either withheld or camouflaged, selection committees admit a tendency to overinterpret the slightest disparaging word. They would rather know all of the good and the bad, and not have to worry about what a letter might be enigmatically trying to tell them. Unfortunately, a bad experience can prejudice future decisions, but most selection committees are open-minded and review each year's applicants anew, albeit more judiciously.

While they hesitate to abandon the letter, their reliance on it declines relative to other methods of evaluation. Like members of other selection committees, Dr. Stephen Goldfinger, associate professor of medicine at the Massachusetts General Hospital, relies on the letter in deciding which of the most competitive "outsiders" should be invited for an interview. Since hospitals customarily interview all the internship applicants from their affiliated medical schools, the letter "would not really affect our decisions about students intimately known to the hospital staff," says Dr. Goldfinger.

Unquestionably, traveling the interview circuit can be costly to the applicant and time-consuming for the interviewer(s). Prescreening is commonplace for popular programs that receive upwards of several hundred applications. Nonetheless, the interview is usually a sine qua non, especially in cases where the Dean's letter has left a bland impression. At stake is not so much scientific showmanship, as the assurance that the applicant and the program will dovetail and prosper for several years. "We are loath to rank any student whom we have not interviewed," according to Dr. Relman. "Personality and character are no less important to us than academic achievement." Candidates should have the opportunity "to savor the personality of the institution," he continues. "There are always a few whose ranking is significantly changed by the interview. I suspect that students also have the same experience in making their ranking of programs."

Recommendation letters from faculty, particularly clinical instructors, also provide input. There is some reservation about this method since it is presumed that students can always engage one or more faculty members to write good recommendations for them. The pediatrics program at Duke solicits letters from residents who tend "to know the students better than many of the Harvard faculty." Such letters appear to divulge more credible information on the applicant's ability to cope with situations of great stress. If the individual author is known to the committee, the letter can be weighted more meaningfully; a number of residency directors frequently seek their colleagues' opinions. Telephone communication, sardonically referred to as the buddy system, is perhaps the most direct source of information but does not command a unanimous following because of its time-consuming nature. Consulting a reference by phone, nevertheless, more often than not guarantees satisfaction. Purely objective data, such as MCAT or National Board scores, are not routinely mentioned in the Dean's letter and are not part of the permanent Medical School transcript.

The program directors in family medicine residencies regard the Dean's letter most positively. These programs are not yet inundated with an extraordinary volume of applications, so that for the small number of Harvard students who apply, the letters do not create a blur. Dr. Hiram Curry, who directs the program at the Medical University of South Carolina Hospitals, characterizes the HMS letter as "among the best we have received during the past seven years. They have been informative, carefully written, and to date have proven to be very accurate."

Once students from HMS are acclimated to the conditions of a particular program, is their performance ever correlated with their profile in the Dean's letter? On occasion, a director reexamines the letter in light of a personality disorder or failure to uphold standards, and reads between the lines with great chagrin. None of the programs we surveyed had attempted to evaluate systematically the letter's predictive value.

Aside from the Dean's letter, another concern voiced by residency directors is that of house officers leaving a program in medicine, surgery, or pediatrics after the first year, to enter another specialty program. Some of the applicants earnestly in pursuit of a program at a famed teaching hospital may be seeking preparation for another specialty program. Because they have other plans in mind, are their chances of getting a good first year position

jeopardized? Are they forced to misrepresent their ultimate goals?

Almost all hospital selection committees recognize that possibility. Many of the program directors that we polled emphasized the flexibility of their programs in accommodating students with divergent career plans. At some hospitals cooperative arrangements have been initiated wherein an internal medicine program will provide a first postgraduate year for a few individuals who intend to finish their residencies in other specialty programs in the same hospital. The logistics of obtaining a broad first year are far from being resolved.

Currently, the organizations concerned with graduate medical education are debating whether a general first year should be mandatory for all of the other specialty residencies, as well as which options are most feasible. This will quite likely intensify some of the present difficulties. Psychiatry, for example, is one specialty that has recently reinstated a general first year requirement. Of the psychiatry programs offered at HMS teaching hospitals, at least two of them make partial provisions for the first year. In the McLean Hospital program, the year is evenly divided between psychiatry, and medicine at the Mt. Auburn Hospital. But "this kind of experience has not been a good one," according to Dr. Philip L. Isenberg '55, who heads McLean's resident education. "Residents spend half of their year in facilities which have not chosen them to be residents in their own program." At the Massachusetts Mental Health Center, a medical internship at the Waltham, the West Roxbury VA, or the Lemuel Shattuck hospital is offered to one half of the incoming residents. Admittedly, "it is complex to try to arrange a program between these other hospitals and ours," acknowledges Dr. Richard Shader, director of training and education. The remainder of the applicants complete the requisite first year elsewhere before entering the MMHC residency program.

Another specialty, ophthalmology, strongly recommends a broad first year. The residency at the Massachusetts Eye and Ear Infirmary, coordinated by Dr. C. Stephen Foster, requires this, but the applicants independently secure positions themselves.

Criticism of the Dean's letter is confined to its role in the selection process. Hospital selection committees insist that a return to a system of dividing the class into thirds or quarters would enable them to make more informed decisions. They would know where the students stand in relation to their peers, as well as the total number of students in each category. Some residency directors fear that without a comparative rating, the superior students will not rise noticeably enough above the rest; others imagine that the solidly good students will not be differentiated from the mediocre ones. But as Dr. Gardella deadpans, the Medical School perceives that "two-thirds to three-thirds of Harvard's students are in the top third."

A return to grades may not be a panacea — witness the complaints of recent years about the inflation of grades — but beleaguered selection committees continue to agitate for specific information. Perhaps a solution is to rely on the letter not as a summary of intellectual acumen, but rather as a record of an individual's "socio-economic background, college and medical school accomplishments, and specific recommendations from major clinical departments especially in the candidate's field," or so reasons Dr. Robert M. Zollinger '59, a member of the basic surgery committee of University Hospitals of Cleveland, who also rates the HMS letters as "uniformly very good." Hospital selection committees concur that the letter should enlighten the reader as candidly as possible about the student's intellectual capabilities and endeavors outside of the regular curriculum, his or her communication skills, performance in clinical clerkships, knowledge of the basic sciences, maturity of personality, and other pertinent details. It is when the letter is too vague that the summary sentence takes on inordinate importance. "The whole process is a bit of a gamble," muses Dr. Zollinger, "in which the Dean's letter, although a most important component, is but one of the evaluation pieces."

In any case, no one expects that the more quantitative evaluations would be weighted at the expense of the composite picture. Diversity in both academic work and personal attributes is fully appreciated. "Harvard students are less stereotyped, a little less predictable and much more interesting than they used to be," asserts Dr. Relman. "As long as Harvard continues to attract a substantial fraction of the very best, there need be no cause for concern."

Despite qualms about the reliability of the Dean's letter, most comments attest to Harvard's high quotient of success in placing students in challenging postgraduate positions, and reflect the integrity of the School's educational process. House officers of HMS origin are frequently described as "absolutely superb," "excellent," "maintaining a high degree of academic competence," and "impressive." Most significantly, the consensus is that in general, house officer performance has been improving every year. With class ranks, grades, or some other type of evaluative comparisons denied them, hospital selection committees still have been able to cull an optimal group of interns and residents.

Also at Harvard, when the Dean's letter has become the responsibility of one individual for a steady period of time, the continuity benefits both the students and the hospitals; all of the parties involved develop a mutual respect and rapport. The author becomes more knowledgeable about the nuances of HMS's curriculum, and confidence in the letter is buttressed.

It seems that hospital selection committees, faced annually with the task of choosing a small number of interns from among a dizzying abundance of highly qualified candidates, will always yearn for additional, clearer, and more measurable information about each candidate. While acknowledging that their choices are almost always validated once the students are in the hospital, program directors naturally grasp for a greater sense of certainty at the moment of choice. Even when class rank was the norm at Harvard, Dr. Gardella remembers receiving notes from colleagues who claimed they had "broken the code." To fully satisfy residency directors, the Dean's letter may have to revert to a code language that they can more readily comprehend.

The matching plan: growing pains

by John S. Graettinger

"Match Day" has been a rite of spring for most medical students for a quarter of a century. What is now the NIRMP has served the majority of graduating students as the process of their transition to the first year of graduate medical education. I shall try to sketch its history and current state — which are, of course, inextricably part of the infancy, adolescence and — speaking optimistically — the early maturation of graduate medical education.

From the turn of the century when the concept of internship began, through the 1940s, it developed as the final year of clinical training for most physicians. By 1935 more than half of graduates in the United States took an internship before entering practice. This was the infancy period of graduate medical education and was relatively tranquil.

The adolescent period, in my view, began immediately after the second world war and lasted through the late 19•)s. By the mid-1940s internships had proliferated to the extent that they considerably exceeded the number of graduates. Not surprisingly, competition grew among programs. Recruitment efforts began to extend to the beginning of the fourth year of medical school, back into the third year, and even, in some instances, back into the second year.

A "Gentlemen's Agreement" was introduced in 1945 in an effort to set a later, uniform appointment date, but its effectiveness, at best, could only be awarded a "Gentlemen's C." In 1949, a "Cooperative Plan for the Appointment of Interns" was introduced at the meeting of the Association of American Medical Colleges in Colorado Springs, resulting in the simultaneous release of telegrams by the hospitals offering positions to students. The first year of the "Telegraphic Plan" was a disaster. Students who got an offer from their second choice hospital were tempted to stall in the hope that they would receive an offer from their first choice hospital. Hospitals had to stall their lower ranked applicants for the same reasons. Some students and hospitals even withdrew earlier acceptances as higher preferences came through with a belated acceptance.

At the next AAMC meeting in October 1950, the National Interassociation Committee on Internships was established to test a mechanical match in 1951 concurrently with the telegraphic plan. At a meeting of the newly formed National Student Intern Committee, representing forty-three schools, the mechanical match received an enthusiastic vote of confidence. The students objected, however, to the proposed "student first choice" algorithm, pointing out that it put a great premium on the adroitness with which they made their first choices of hospitals and downgraded subsequent choices. The students successfully urged the adoption of a "hospital first choice" algorithm, which eliminated the possibility of a student being bypassed on a hospital's rank order list by a lower-ranked student.

Dr. Graettinger

Among Harvard's contributions to the beginnings of the matching program was the "Boston Pool Plan," which had successfully been used in the Harvard hospitals for several years as the model for the match, and the use of the card-sorting machines in the business office of the MGH, on which the mechanical match was first tested.

In 1953, the NICI became the National Intern Matching Program (NIMP) with a board of directors representing the Association of American Medical Colleges, the American Medical Association, the American, Protestant and Catholic Hospital Associations, and students. Fifteen years later, because of the increasing diversity of graduate medical education, the American Board

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> "The problems at the juncture lie not in the NIRMP mechanism, but in the growth of medical education as a whole."

of Medical Specialties was added as a parent and the name changed to the National Intern and Resident Matching Program (NIRMP). The fifteen board members now include one student representative from the American Medical Student Association, one from the Organization of Student Representatives and a student at large.

This adolescent period was quite satisfactory. A growing number of graduates were matched to an increasing number of internships. Why did it work? In the first place, although some internships were rotating, some straight and some mixed, the year was a relatively standardized and clearly defined experience. Second, well over ninety-five per cent of students participated. Third, almost all of the hospitals offering internships also participated, even though less than half were affiliated with a medical school. Finally, a quasi-insitutional function came to be carried out in most hospitals by an "intern" or "house staff" committee.

During the same period residencies were proliferating, until by the '50s there were more residency positions than interns to fill them. Several important differences between the development of residencies and that of internships led to some current problems. Residencies grew, beholden not to institutions as much as to specialty boards, residency review committees, associations of professors of each specialty and specialty societies. They developed primarily with the tertiary care institutions in which most undergraduate medical education also was taking place. The residency programs within such institutions were quite heterogenous and autonomous. As had happened with internships, earlier and earlier pressures on students for residency appointments developed. Students who were applicants for some types of residencies were asked to make commitments before their basic clerkships in medical school were completed and before they obtained their internships.

During the next decade, several attempted "gentlemen's agreements" died a-borning, hampered by lack of participation and the ambiguous status of the first year of residency. In 1959, a gentlemen's agreement for a uniform date of residency appointment was introduced by psychiatry. Seven years later — the same interval that had elapsed between a gentlemen's agreement for the internship and the NIMP — the first residency matching program was started by the psychiatrists. History does repeat itself! Unfortunately, that was (and is) the specialty that had fewest of its institutions affiliated with medical centers. It lasted two years, and failed because less than half of the programs joined it. A pediatricians' gentlemen's agreement in 1964 was followed by a residency match in 1968, which failed after a single year because the first year of residency was not clearly defined. Was it the same as a straight internship in pediatrics and was there an implicit commitment to a second year, or did the first residency year begin at the level of the second year of post graduate training? There were also attempts at residency matching in radiology, in orthopedics, and at the present time several others are being considered.

The adolescence of graduate medical education was becoming increasingly turbulent. In 1968 the report of the Citizens Commission on Graduate Medical Education, (the Millis Report) appeared, recommending the abolition of the internship in hospitals without residencies, the integration of the first with the advanced years of graduate medical education, and the assumption of responsibility by institutions for all of their programs. The first two changes were implemented by 1975. The Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education, both formed by the same groups that founded the NIRMP, were to regulate the accreditation of residency programs by the residency review committees in each specialty. At the same time, the Internship Review Committee disappeared — leaving no accrediting body to look horizontally at the first postgraduate year.

The reactions of the specialty boards and program directors to the Millis Report were varied. In 1968, obstetrics no longer required an internship and, by 1971, most specialties no longer did. The NIRMP board of directors announced at that time that it would match any approved applicant to any approved program and also said that all programs offered by an institution to graduating students had to be offered via the NIRMP or none could be offered. This was the famous (or infamous) "all or none" rule.

In internal medicine, general surgery and pediatrics, the abolition of the internship simply meant that the large numbers of straight internships they already offered would now be termed first year residencies. However, in the medical and surgical specialties and the others that traditionally recruited interns, program directors faced the dilemma of two possible sources of physicians for their first residency year. They could recruit students — which meant participating in the NIRMP with its "all or none" rule and its much later appointment dates, and also might involve arranging for a general clinical experience with their colleagues in the broader specialties. Alternatively, they could continue to appoint from those who had had a first year.

This predicament has resulted in the forty-one different types of programs in over twenty specialties now confronting students in the NIRMP. In the smaller medical and surgical specialties, less than a third of available positions are offered as first year positions in the match and the rest as second year positions. This has meant that after some students have signed up for a first year of residency in such programs in their third or fourth years, to start in their second post-M.D. year, they also have had to obtain a first broad clinical year. Many program directors in the broad specialties have not been interested in having such students for only one year. As program directors and students have been wrestling with these complications, the boards have begun to come full circle and to re-institute a requirement for a broad first year. Thus the current situation is problematic for both students and program directors.

Supply and demand problems have also developed. Hospitals are beginning to face shrinking resources at the same time that an increasing number of students, who have been entering medical school since the late 1960s, are seeking positions in graduate medical education (see Fig. 1).

In addition, the number of graduates of foreign medical schools who applied reached 6,000 in 1976. Although their number decreased by over a thousand this year, and can be expected to decrease further as a consequence of the new health manpower law, the number of positions per applicant in the NIRMP has become less than 1:1 for all applicants and only 1:1.2 for US graduates.

Recent trends in graduate medical education have run parallel to, or perhaps even anticipated, the current public interest in primary care. Graduating students have strongly opted for the generalist specialties of family practice, internal medicine, pediatrics and obstetrics in the past several years, and the medical school affiliated hospitals have responded very well in making more positions available to them. Since 1974 the total number of positions offered in the NIRMP in these specialties has increased by 2,400 and the number offered in all of the others has decreased by over eight hundred. Sixty-nine per cent of this year's graduates chose the broad specialties of family practice (14%), internal medicine (39%), pediatrics (10%) and obstetrics (6%). Psychiatry was the choice of four per cent. General surgery is the first choice of thirteen per cent and the surgical specialties of another three per cent. The "non-bedded" or support specialties of anesthesiology, pathology, physical medicine and radiology are sought by five per cent and flexible residencies (programs sponsored by at least two approved specialty residency programs) by only seven per cent. Although some of the graduates entering the generalist specialties for a first year will enter narrower specialties and subspecialties in subsequent years of training, the ranks of physicians trained in the generalist specialties are clearly growing.

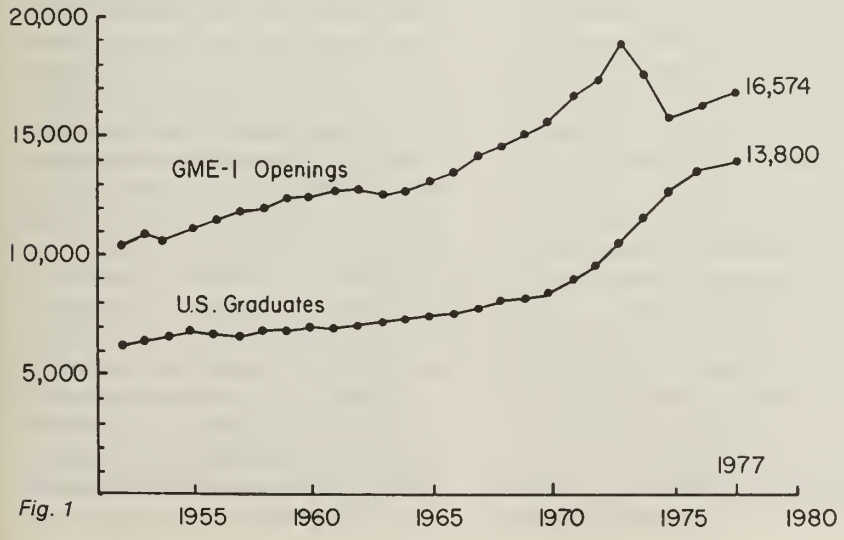


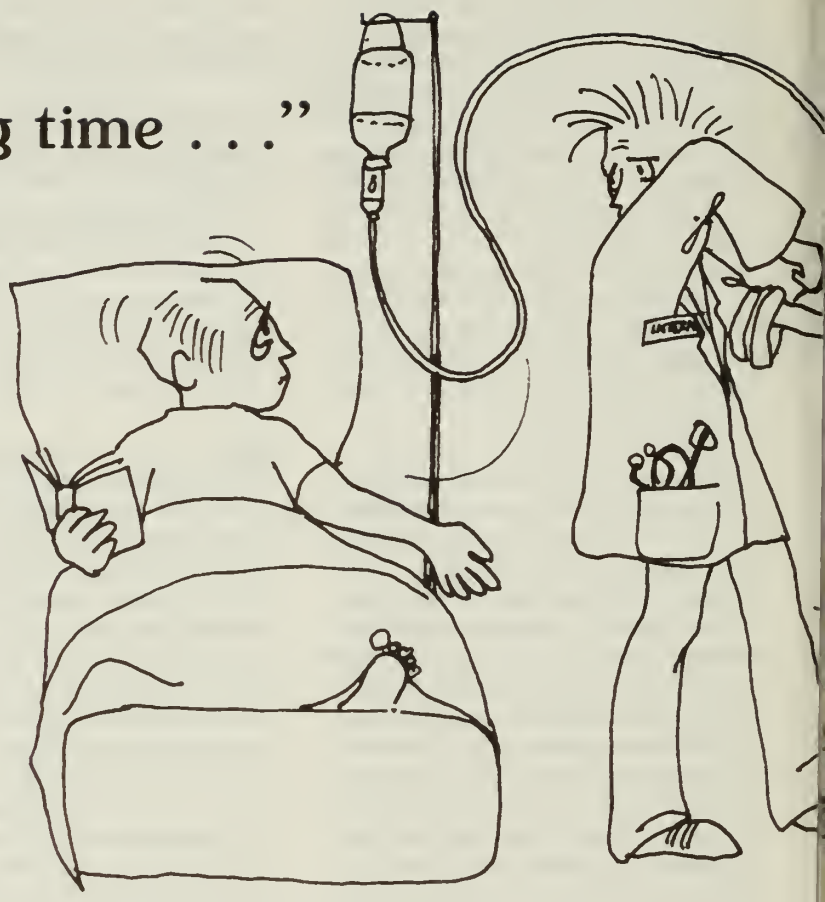
Fig. 1

Not all US graduates, however, obtain their positions through the match. In addition to those who are unmatched, others legitimately withdraw to enter the armed forces, to take other than a clinical year, to negotiate as couples outside of the program, or as January graduates — or to take a position in a hospital which does not participate in NIRMP. With the help of the deans, we have just completed a study of the twenty per cent who obtained their positions outside the NIRMP in 1976 and added the results to those who matched: the distribution in types of programs was essentially the same.

In my view the NIRMP is functioning remarkably well in facilitating the passage from the undergraduate to the graduate phase of the seven to eleven years' experience it now takes to complete the formal medical education of a physician following college. The aspiring physician begins as a student and optimally evolves into a self-educating professional. The problems at the juncture lie not in the NIRMP mechanism, but in the growth of medical education as a whole. In contrast to the coordinated faculty management of admissions, curriculum and evaluation in the medical schools, in their affiliated hospitals these same functions are commonly carried out in an anarchic manner by members of the same faculties acting as autonomous barons. When the medical schools and their teaching hospitals overtly recognize, by planning and concerted action, that the two formal periods of learning represent a continuum, graduate medical education will have come of age, NIRMP will better serve the transition, and our professional progeny and program directors will be less in turmoil at the approach of "Match Day."

INTERNSHIP 1975

"A year is a very long time . . ."



by Victor Strasburger

It wasn't until internship that I realized I never really wanted to be a doctor at all. I had simply wanted to stay in school for the rest of my life, and going to medical school had seemed the best way of accomplishing that.

All of a sudden it's midnight, June 25, the first day of internship, and I've gotten five admissions and four more are coming during the night, strategically placed so that I will be denied solace, sleep, or even time to call my mother in Baltimore and cry. I had walked in to work that day expecting to be oriented. At our hospital, it turned out, orientation meant showing you the cafeteria, introducing you to the librarian, and explaining that medical records were meant to be completed promptly. They didn't even show us where the bathrooms were. It was an omen.

I'm on the infant ward, and three of the newborns need arterial lines.

"Why don't you go ahead and start putting in the first one?" my unsuspecting resident asks me.

"First one what?" I counter.

"The first arterial line."

"What are they?" I ask, eager to be taught.

He groans like I had just delivered a haymaker to his solar plexus. "Didn't they teach you *anything* at Harvard?" he asks viciously.

"Who said anything about Harvard?" I look at him innocently. "You've got me confused with someone else. I went to Idaho State." Little did he know that when I was doing neonatology at Harvard, the interns and residents barely knew how to work the respirators, much less put in umbilical artery lines. Students were invited to stay away from such procedures, presumably because they would quickly discover that very few people really knew what they were doing in neonatology at Harvard. Harvard may be Mecca, but only if you're not a premie.

That first night on call as an intern may have been the most miserable night in my life (it's really a toss-up between that night and the night I made my first lasagna in order to impress my girlfriend and put in an entire head of garlic, thinking it was one clove). The only way I got through it was by telling myself that this was the absolute worst; it could never possibly get any worse than this. It was not the first time in my life that I had lied to myself.

There is, in fact, only one good thing about being an intern: you don't have to get your orders cosigned. That's it. The money? You never notice it. You'd gladly pay fifty dollars an hour some nights just for a little sleep. You never have time to enjoy your money anyway. How can you treat your stomach to a Saturday evening of fine French food when you and it both know that you're going to be on call the following day, all day and all night. The nurses? Come on, *really.* Why would they want to go out with some klutzy intern like you? The status? *Status* is a Mommy and Daddy word, but they can never reach you on the phone to tell you that that's what you've got because you're always either in the hospital or semi-comatose in bed. The first time someone called me "Dr. Strasburger" I thought they were talking about my father, and he's a lawyer.

But listen. If you insist on going through with it, I mean if you've really got your heart set on it, then I better give you a few rules to survive by:

(1) Destroy your beeper as soon as it is given to you, sooner if you can somehow manage it. Whoever made Marty Feldman's eyes also designed beepers. If you can't destroy it completely, make

"I NEED THIS MORE THAN YOU . . ."

sure you deactivate the device that's set to go off any time you enter a bathroom or sit down to eat.

(2) You're not paranoid. They really *are* out to get you, and you might as well face up to it. *Everyone* is, from the Chief of Service to the janitor who's always washing the floors as you walk by, hoping you'll slip and break your neck.

(3) Never d/c a functioning i.v.

(4) It's never like the movies. Lew Ayres and John Barrymore just didn't know what was *happening*. I'll never forget the time in my first year when I got stat-paged to the intensive care unit in the middle of working up a new admission. One of my patients with chronic renal failure and pulmonary edema was now going into a digitoxic rhythm and was trying very hard to die. It took me two solid hours to get her going again, and meanwhile I asked someone else to look after the patient downstairs. *(continued on p. 26)*

INTERNSHIP 1963

Internship is no time for sleeping

by Paul J. Davis

Many of today's medical graduates do not realize that house staff training flourished in an era which preceded the Xerox machine, Larry Weed and the Washington University Manual. I have written about such an era *(In One Era and Out the Other: The Auscultatory Gap,* reprinted in paperback as *Can We Bridge the Auscultatory Gap?)* and will continue to do so. Those were turbulent times for which we were not especially well-prepared.

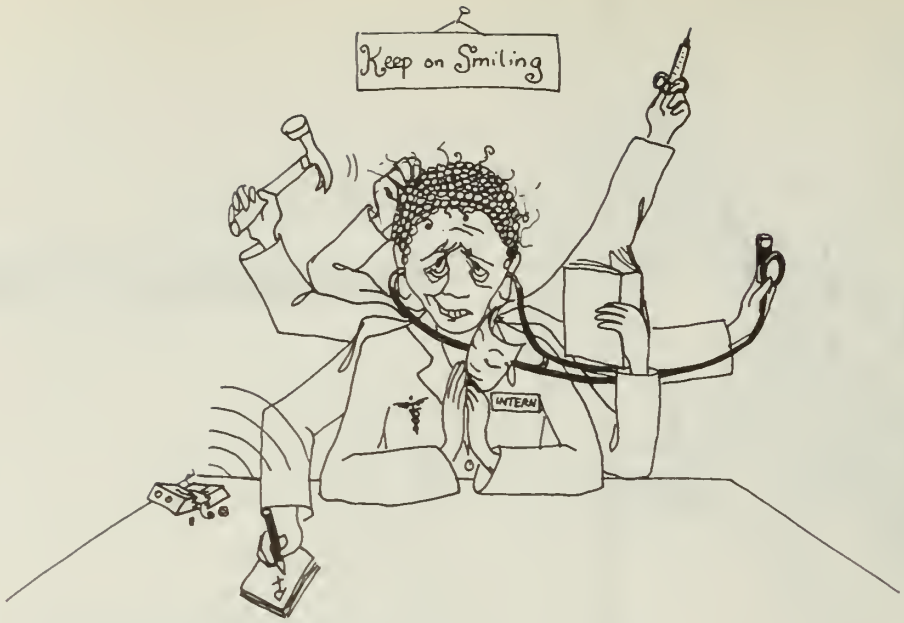
For example, I was not well-prepared to live in a New York City borough during my house officership. We — I and my wife and physician-companion, Faith — chose to live in an apartment high above the Hudson River, from which we could chart the flotsam in its inevitable course from Poughkeepsie to Staten Island. We moved to New York oblivious to the fact that the metropolis was gripped by a (chiefly nocturnal) insect pest problem (IPP). We spent almost all of our free time during postgraduate year 1 through PGY-4 experimenting with a wide variety of chemical agents (most of which went directly to our livers or marrow), which had been developed to enable New Yorkers to cope with the IPP. Virtually all urban house staff, I subsequently learned, have had to confront the IPP.

I was also not prepared for a curious genre of fatigue, fatigue which was enervating, pervasive, miasmatic and numbing, yet agreeably convivial. In those halcyon days of the every-other-night-or-oftener-on-call schedule, it was possible to plumb new depths of fatigue by the end of each successive forty-eight hour stint. As Brown-Séquard wrote (in *L'Interne Exténué),* "Tired house staff don't complain about the health care delivery system." We didn't, and we learned that first-rate ward clerks and clinic clerks are the core of efficient patient management programs.

I was fascinated by my wife's near-perfect adjustment to the rigors of long hours and insufficient sleep. Raised in an indulgent society which permitted her, prior to internship, the luxury of nine hours of sleep each day, she continued to get her quota during PGY-1 by learning to sleep in the upright posture, bright-eyed, usually with a lighted cigarette in her mouth. It was uncanny to see her perform at attending rounds. *(continued on p. 27)*

Having survived his internship and residency years at the Bronx Municipal Hospital Center in New York City, Dr. Paul J. Davis '63 is now a professor of medicine at the State University of New York at Buffalo, and frequently writes about critical medical matters. He is married to Faith Baker Davis '63.

Victor Strasburger '75 did his internship at the Children's Hospital in Seattle, and has just begun a senior residency in pediatrics at the Children's Hospital Medical Center in Boston. He has one published novel, Rounding Third and Heading Home, *about a seventeen-year-old boy's struggles to "find himself." His recently completed second novel,* First Do No Harm, *is about Harvard Medical School.*



INTERNSHIP 1975

The new admission, it turns out, was an eight-year-old little girl who was sent in for vomiting and dehydration by her private doctor. By the time someone else got to see her, it was five hours after she had been admitted, and the private doctor was having a fit. I got chewed out by both him and the Chief of Staff for letting such an unconscionable thing happen. Did they care what I had been doing? Did it matter that I had been saving some poor girl's life in the ICU? Of course not. A private patient, admitted to receive intravenous therapy, should get intravenous therapy within an hour of her admission. No exceptions made. (The little girl, by the way, was so dehydrated that she went home the next day. And I am proud to say that my ICU patient is still alive and well, no thanks to my Chief of Staff.) I had fully expected to be carried around in an easy chair for the rest of the day by four social workers, one on each leg, because I had saved a girl's life.

Seriously (I'll try to be, honest I will) there are a number of things to be learned during your internship. The first, and by far the most terrifying, is that you are not the master of your fate. You are in a service profession, just like a bartender or waiter, except that the bar is always open and the restaurant is really a twenty-four hour pit-stop (hence the expression, "the pits"). For all of the prestige of the profession that you thought you were getting, it is a rude surprise to learn that you serve the people, and not the other way around. Translated, this means that when your tenth admission arrives at 4 a.m., you have to treat him like he was your first, not try and smother him with a pillow before your resident arrives. The *patient* doesn't know how many admissions you've had that day; and he shouldn't have to suffer just because he picked an inopportune time to get sick.

The second thing is that no one understands anything but a smile. People do not cope well with your anger and hostility, no matter how justified it may be. I went on the warpath for three months of my internship, and a sizeable segment of the nursing population at my hospital still thinks I should be strung up by my gubernaculum. Unfortunately, there are very few socially acceptable outlets for your anger and frustration when you're interning. *Don't* try playing basketball with your fellow interns. Don't take it out on your girlfriend, boyfriend or spouse, or you will rapidly become a statistic. On the other hand, you can't just "leave it at the office." My suggestion would be to find some kindly older clinician to confide in at least once a week. Commiserating with your fellow interns usually winds up making you feel even worse. And residents have notoriously short memories — you would think that they interned twenty years ago, in the days of the "Iron Men," instead of a few short months ago.

The third thing is to enjoy yourself, or at least enjoy what you can. Enjoy your patients, at least. Me? I hate work. I hate hospitals. I hate sick people. But, God, I love being around kids. My favorite patients I usually tried to follow in my own continuity clinic so that I would not lose the enjoyment that they could bring me. Selfish? Sure, but who's to know? It's called "good medical care" when you're interested in your patients.

"WHEN YOUR TENTH ADMISSION ARRIVES AT 4 A.M., YOU HAVE TO TREAT HIM LIKE HE WAS YOUR FIRST, NOT TRY AND SMOTHER HIM WITH A PILLOW BEFORE YOUR RESIDENT ARRIVES."

Fourth, don't be afraid to admit your ignorance, but you can't let it get you down either. Everybody feels dumb when they start. Some people actually are. And some actually get dumber as they go along. But that's not *you* I'm talking about, so don't worry.

And finally, don't ever be afraid to step back a little distance and ask some good hard questions, like: should you really be a doctor? What does suicide feel like? Is it really worth saving a baby with a myelomeningocele at T10 who has meningitis? Is it really worth spending $50,000 to keep a twenty-eight week premie alive for three months? Why do the nicest people have the worst diseases? Why don't evil people get sick more often? Keep a diary, take pictures, do whatever you have to in order to get some little bit of perspective on internship. Don't believe people who tell you that it's only a year. A year is a very long time.

Most of internship is so bad it's really pretty funny, and the rest of it I don't even want to talk about.

The latter feat always attracted house staff from other wards (indeed, other hospitals) who came as disciples, to learn how she did it. Even I was not privy to her method, although several times I thought I caught a glimpse of a list of mantras engraved on the handle of her neurological hammer.

I was unprepared for the incubus of malpractice suits which, even fifteen years ago, came to be a menace (see my reflective monograph, *Malpractice: Occupation or Preoccupation?)*. I have to confess I periodically fantasized courtroom appearances, defending what I saw to be an extraordinarily high level of medical care interrupted by Acts of God, interpreted by silver-throated barristers as acts of man. In my reveries I usually had at least one opportunity to say dramatically, "Lawyer, sue thyself!", a turn of phrase which always drew polite applause from a gallery of counterculture consumers who religiously attended these sessions.

I was also unprepared for the welter of extraordinarily good people who, as patients looking for primary physicians, came to our institution and warmed to it, despite its monolithic character. The obligation to personalize the institution was seen by many of us to be our responsibility. While it is true that many of us engaged in confrontational politics in dealing with the City of New York for higher wages, within our individual institutions there was very little adversarial posturing between house staff and administration.

I was prepared for, and expected, a group of house officers who were excellent. They were. They remain remarkable. The hospital's faculty was in a phase of logarithmic growth during the early 1960s and influenced many of us, in insidious ways, to enter academic medicine, where, today, we are grantless, apprehensive, confused, challenged, usually resolute, contributory and rather happy.

Several people have asked me who my role models were or are. Probably some medical school faculty member, they speculate, or an uncle who was a veterinarian. I failed to select a role model until I reached residency when, as many of you know, I chose S. J. Perelman. That is, I decided I wanted to be the kind of doctor S. J. Perelman would have been if S. J. Perelman had been a doctor. As a result, I wrote many extraordinarily funny and complex short stories during PGY-1 through PGY-4 and submitted every last one of them, reeking of Raid,® to *The New Yorker* magazine, whose editorial staff, I am sorry to say, continued to publish only Perelman and ignored my own work.

"TIRED HOUSE STAFF DON'T COMPLAIN ABOUT THE HEALTH CARE DELIVERY SYSTEM."

My manuscripts were invaluable, I was given to understand, in the magazine's pest control program.

In a 1960 survey, Lyden, Geiger and Peterson tell us that eighty per cent of "good physicians" are satisfied with their residency training. Written before the unrest of the mid-1960s and early '70s, their book if written today would presumably reflect a higher level of dissatisfaction, if only because today the act of grousing has an element of fashionability to it. Because I am thirty-nine and graying, I seem to have developed a rheumy view of the 1963-1967 quadrennium and find what Ronald Reagan has to say increasingly and reassuringly insightful. As I look back on those four years, I think they may even have been e*xhilarating* years . . . Obsessively assembling the data base at cock's crow, savoring the midnight supper on nights-on (oh, those little crêpes filled with chicken, spinach and cheese), dealing in medical hyperbole with one's colleagues, the exultation of a fifth admission by 5 P.M.!

It was Dean Fluegel, later Chancellor Fluegel, who wrote (in his autobiography, *Der Fluegel Blows His Own Horn)*, "Give me a fantastic midnight supper and I'll give you a contented house staff!"

Taking a *year on* for research

by Prentiss B. Taylor, Jr.

"Increasingly, medical students are caught up in the research enterprise. Some desire careers as academic clinicians, a smaller group seeks careers on the faculties of preclinical departments, and some simply taste research and go on to careers in private practice . . . Research is an exercise in biological problem solving; so too is clinical diagnosis. And the physician will be more proficient at his art if he fully appreciates the caveats to be associated with claims . . . made in the medical literature, which he must continue to study throughout his professional career. There can be no better means for learning how extraordinarily difficult it is to 'prove' something in the laboratory or clinic than trying one's own hand at it."[1]

Not long ago, Dean Ebert stated at a public forum that as many as twenty per cent of recent HMS classes have been electing to spend five years here in some type of expanded program. By my calculations, seventeen per cent of the Class of 1977 is in this category, choosing to devote a year to laboratory investigation or to master's programs in public policy or public health. Several of these students are using their work as the basis for an M.D. honors thesis.

As his article makes clear, it was not fear of internship that persuaded Prentiss B. Taylor, Jr. '78 to opt for a five year program. He has spent the past year doing research in a laboratory at the Children's Hospital Medical Center, in preparation of an M.D. thesis in developmental neurobiology. Originally a member of the Class of 1977, Mr. Taylor will graduate next June.

My own reason for choosing the five-year thesis option was similar to that of other students who felt that the core curriculum was not satisfying their desires for personal creativity; the extra year would be a comfortable compromise between the conventional route and an even longer M.D.-Ph.D. program. Out of curiosity and a desire for camaraderie, I surveyed a number of recent graduates and current students about their decision to devote a large block of time to basic research, often taking a year "off," as it were, from the traditional progressions of medical school. What I found was a group of budding intellectuals who, with few exceptions, counted their laboratory experiences among their best moments in medical school. Indeed, one enthusiast reported that "these were the most educational months I've spent since kindergarten."

Repeatedly, these young researchers commented that "there's a lot to be said for the old master-apprentice relationship." Even though the nature of the thesis project focused their efforts on developing competence in a narrow area, they felt that their work with highly experienced preceptors pioneering on the forefront of biomedical knowledge yielded lasting insights of much broader scope. The guidance and example of these seasoned experimenters honed their judgment about what types of research approaches are and are not likely to lead to new knowledge of substantial clinical relevance. However, this was an intangible benefit, whose promise can take years to bear fruit.[2]

Such tangibles are not always easy to translate to friends and family outside, or even inside, the medical profession. My med-student cohorts reacted to my decision to do a thesis year in various ways, some derisively, often teasing, "Have you been nominated for the Nobel Prize yet?" Others were positive that anyone doing a year of research was taking a vacation from the seventy-five to eighty hour weekly grind of medical school — perhaps a faint heart fleeing from late-night management of gunshot wounds or from sitting up past 3 A.M. with an end-stage cystic fibrosis patient who would never see another sunrise.

My parents and close relatives tried to be understanding, yet they found subtle ways of reminding me that my great-grandfathers were slaves, my grandfathers struggling Mississippi farmers, and my father a Pullman porter toting bags on trains out of Chicago. As they saw it, I should not dampen the full uplift of this century of uninterrupted upward economic mobility by training as a scholar — at the expense of optimum financial benefits for the entire extended family. But on the other hand, my parents and in-laws have shown reprints of my articles to friends with pride, and my younger brother in high school asks me for advice about his interests in marine biology.

The M.D.-Ph.D. students accepted me as a peer once they heard that I was exploring opportunities to go to NIH as part of my residency program and that my interest and involvement in research would definitely be continued at a later stage. In their view we shared the same dilemma: the prospect of losing touch with our research interests for the sake of our postgraduate clinical training. Few find this an insuperable challenge (after all, one can still keep up with the

Mr. Taylor

"ONE ENTHUSIAST REPORTED THAT 'THESE WERE THE MOST EDUCATIONAL MONTHS I'VE SPENT SINCE KINDERGARTEN.' "

relevant journals in the clinical period), but many find it a doubly insecure one in having to confront juries of markedly different persuasions — the clinicians and the basic scientists. On the one hand there is a scramble to have at our fingertips clinical journal articles that speak to the germaneness (no matter how indirect) of our basic research to clinical problems. On the other hand, we feel the need to spend extra months laboring to make preliminarily exciting results intellectually respectable by running our methods through a gamut of variations. Neither of these goals is ever completely met, and that is where the experienced preceptor can be wisest and most encouraging: this dual challenge is seldom satisfied in "the real world" either. But we still strive.

Over the course of the research period, my curriculum advisor was, by far, the most supportive person I encountered. Although I avoided becoming dependent on him, on the few occasions that we talked together he managed to allay my fears that I was not — even in one highly intensive year — becoming a virtuoso in biochemical techniques. From his long years of experience in academic medicine, he counseled me that the techniques prevailing at any one time must be viewed with a certain street-wise perspective. "Methods," he said, "are like the trolley cars that pass under my office window. They come along rapidly, and many jump on for the ride. After they have taken us a few blocks ahead, they become obsolete as they are overtaken by newer, swifter models." What is important, he suggested, are the larger questions: what is the destination, what shortcuts can get us there, and is the shortest way the best way to go?

One factor that makes the research year option attractive is that even though students may labor just as hard and long as they would in the clinic, laboratory research definitely has a superior ambience. There is more of a sense of a group effort and fewer categorical role distinctions among its members. Indeed, the young alumni and students I surveyed repeatedly spoke warmly of "having been accepted as an equal, integral part of the research team, with attendant privileges and responsibilities." Perhaps this is due to the value of originality and creativity when working on the frontiers of knowledge. Several department heads have commented that they find it particularly exciting to have an enthusiastic student in their laboratories because "he or she comes with a fresh perspective, and often can see possibilities that those of us with biasing experience might tend to gloss over." The students also found that not every idea they had was relevant or feasible, but the small minority that were generally led to a highly favorable outcome.

In the lab, the future doctor is humbled to find that Ph.D.'s often view physicians as arrogant and pompous. As befits their patient contact role, physicians and medical students tend to dress much more formally (and stylishly) than do many scientists and graduate science students. Not being a particularly fastidious dresser, I was quite surprised to be "dressed-down" by some of my colleagues in my first few weeks in the lab, when I had come in what I considered to be deliberately informal, even disheveled, attire. But this was all part of the ongoing humor, and I had to agree with some of my co-workers' assertions that most physicians are "hopelessly bourgeois."

For me, the difference in ambience was notable for its gastronomical revelations. A laboratory team, having tasks that keep it confined to one or two floors instead of an entire hospital complex, is more likely than a clinical team to eat many lunches and dinners together. My sponsor and his wife took me to dinner to "talk science" one evening with a visiting neurochemist from Utah, thereby introducing me to Szechuan Chinese cooking. Over giant communal bowls of Kung Pao Chi Ding and hot and sour soup, we discussed the future of work on Nerve Growth Factor and current problems of funding by extramural NIH grants. One of the postdoctoral fellows in the lab was an expert in Chinese cooking styles, and was always bringing in surprise lunchtime treats. This caught on very well, and the forty-odd people in our neuroscience group eventually became infamous for using even the slightest pretext to organize an inexpensive banquet at Shanghai Garden, Hunan, Colleen's, or other Boston-Cambridge Mandarin-Szechuan eateries.

Another culinary occasion was the Thursday noon seminar. Every week, one of the postdoctoral fellows, students, professors, or technicians gave a forty-minute presentation of ongoing projects, and the rest of the band "needled" the presenter in his or her tender parts. One person would always bring in a home-cooked snack for the others and with the variety of foreign fellows that were present, we had Middle Eastern hoomis and tahini, Brié cheese with French crackers, thick-crusted German strudel, Chinese wontons, Mexican gazpacho soup, Greek feta cheese, and Italian canoli. Knowing deep in my heart that American physicians (unlike American scientists, of course) have to guard against being "hopelessly bourgeois," my own contributions were two offerings of soul-food pies, pecan and sweet potato. I was stunned to find that most of the Europeans had never before tasted a potato pie. They were ecstatic! (Frankly, I was too proud to admit I'd never tasted Brié cheese before — perhaps because my reaction to it was more like agony than ecstasy.)

The cleverest entrant in these Thursday ethnic cook-offs was an All-American postdoc who brought in a traditional double-layered frosted cake — decorated with the 9 + 2 arrangement of microtubules, whose neurochemical functions he was investigating. In an attempt to protect his creation until it was photographed, he warned us that the icing was made with colchicine (a microtubule poison). But we were hungry that day, and by the time a flashcube was found, the nature of microtubules seemed to devolve from some type of 2 + 1 hypothesis, much to the horror of our cell biology enthusiasts.

After the ravenous researchers . . .

"TODAY THERE ARE FAR TOO MANY PEOPLE RACING BACK AND FORTH BETWEEN THE LAB AND THEIR CLINICAL PRACTICE AND THEY AREN'T DOING EITHER ONE VERY WELL."

Although students who decide on the M.D. thesis option are soon beset by the problems of independent investigation identified by some HMS seniors a decade ago — "pitfalls of experimental design, the failure of devices, the paucity and . . . the incomprehensibility of data"[3] — they are also benefited by unique advantages. Chief among these is close acquaintance with role models who are *not* professors, but incipient scholars often freshly returned from NIH or just out of residency programs. Many of these postgraduate fellows are striving to become known for being clever as well as diligent, as they struggle to make their way up the highly competitive academic ladder. They often have particularly down-to-earth advice about certain myths prevalent within academic medicine.

One astute NIH returnee advised me: "It is important that you try over the next few years to make a clearcut decision about whether you are going to devote yourself to making basic science contributions that have clinical relevance or to being a fully competent physician. I strongly feel that almost no one can do both, unless one has very special gifts. Not today you can't. That may have been true in Oliver Wendell Holmes's time, when people could do basic work, and clinical research involved reasoning such as 'Hey, maybe our patients would do better if we washed our hands more often.' Today there are far too many people racing back and forth between the lab and their clinical practice and they aren't doing either one very well." He went on to tell me stories about certain physician-investigators at his distinguished hospital who try to treat patients in status epilepticus with I.M. phenytoin — a route of administration in which very little of the drug gets into the bloodstream.

Of all these experiences and influences, the students and recent graduates with whom I spoke have found two particular ones most enriching and inspiring. The first is that at the end of the research year, you have accomplished a truly creative deed: your name is on a published article, often as the first author. You have the feeling that you have contributed to evolution in your own small way. This is different from running very hard in the everyday world only to see things stay just as bad as they were when you started.

The second influence comes when you return to the wards. At the bedside of a cachectic eighteen-year-old girl slipping into the terminal, bone-aching stages of an advanced, widely-metastasized serous cystadenocarcinoma of the ovary, you gain ultimate perspective on the meaning of your little year. This dying girl and the Creator within her touch your hand, head, and heart. Larger contributions is the plaintive desire and a tacit demand.

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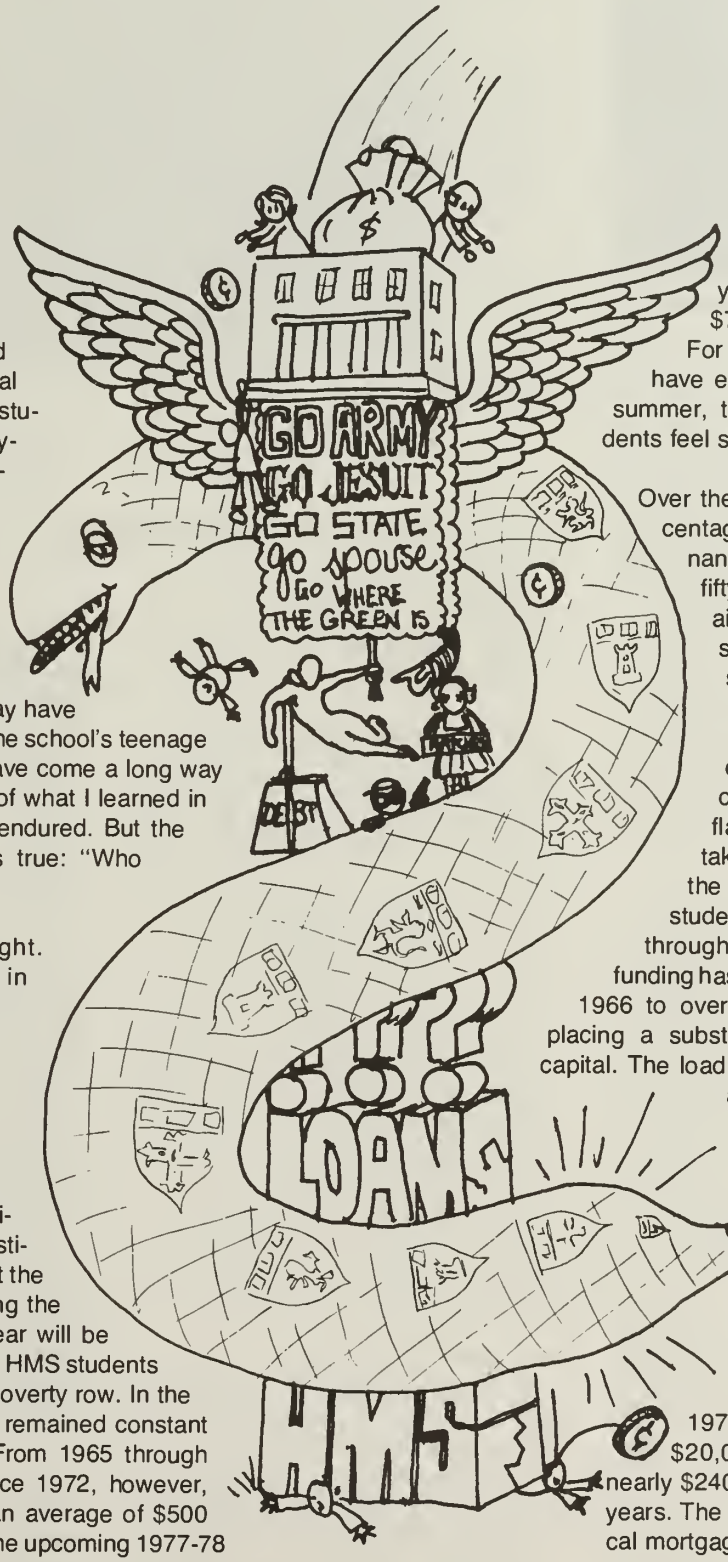
Who pays?

by John Levine

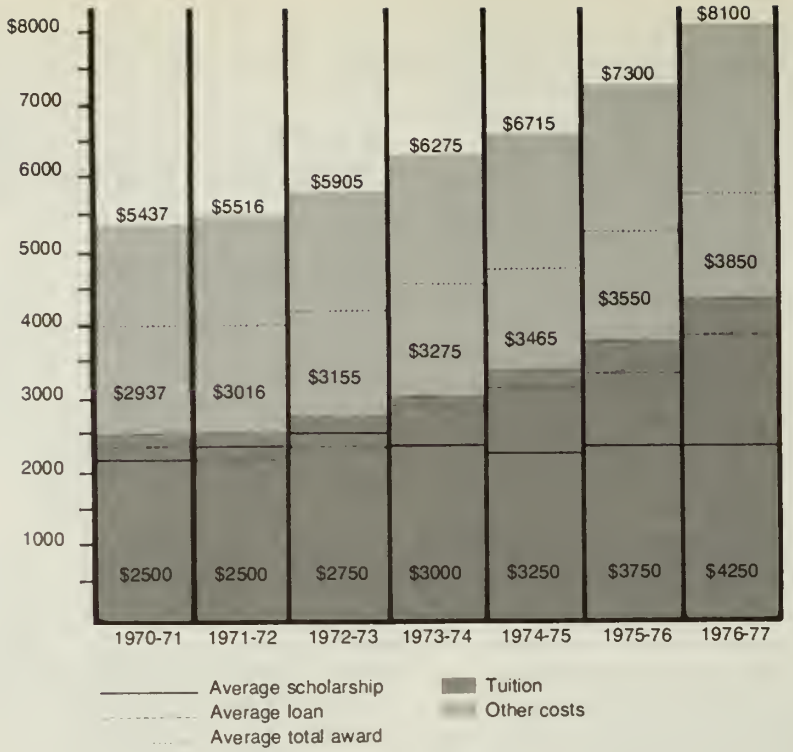


Back in 1964, when I was a senior at Andover, rumor had it that a prominent coach and history teacher had a special section for American history students whose talents on the playing field exceeded their scholarly interest. Reportedly, no matter what topic was being discussed, whether tariff or social program, the coach would shout, "Who pays?" And in unison a cheer would resound, "The consumer pays!" This story may have been apocryphal, but it made the school's teenage intelligentsia feel smug. We have come a long way since the middle 1960s. Little of what I learned in that academic marathon has endured. But the voice of the coach still rings true: "Who pays? The consumer pays!"

Nowadays money is tight. Medical education is in great demand, but its exorbitant cost is the nemesis of a large segment of the nation's medical undergraduates. This, perhaps, is even more true at Harvard Medical School, where everything seems larger than life. The official word is that "the best estimate at this time of year is that the minimal overall cost for meeting the essential needs of the first year will be $9300." After deducting tuition, HMS students can end up living this side of poverty row. In the good old days, tuition at HMS remained constant for several years at a time. From 1965 through 1969, tuition was $2,000. Since 1972, however, tuition costs have escalated an average of $500 annually, reaching $5,000 for the upcoming 1977-78 year. The latter figure is up $750 from the previous year. For individuals who may never have earned more than $800 in a summer, these are large sums. Students feel staggered.

Over the last twelve years, the percentage of students receiving financial aid has increased from fifty-two to sixty-six. Financial aid consists of loans and, in special cases, supplemental scholarships; Harvard stipulates that the first $5,000 of need be met with a loan. Because scholarship funds could not keep pace with inflation, student loans have taken up the slack. Altogether, the amount of money loaned to students is twice that awarded through scholarships. Total loan funding has increased from $295,914 in 1966 to over $1,600,000 in 1976, thus placing a substantial burden on available capital. The load on students has also risen appreciably. Ten years ago the mean individual loan was about $1,400, compared to the present estimate of $5,000; for a member of the class of 1977, the estimated mean indivdiual loan at graduation is $15,000; for a member of the class of 1979, it will be in excess of $20,000. With interest, that's nearly $240 per month for the next ten years. The era of the fifteen-year medical mortgage may be coming.

The unsinkable Jim Pates and June McFee



Note: Because the number of scholarships each year is smaller than the number of loans, the Average Total Award is less than the sum of the Average Scholarship and the Average Loan.

Contrary to the practice of a few other high-priced schools, Harvard chooses not to underwrite fully the costs of any individual student's education by granting a four year scholarship, but rather to distribute the wealth among all the students who need help. Some small number of applicants may thus be lost to HMS. Despite the money crunch, Harvard still considers applicants without regard to financial status. This laudable policy, which enables students without substantial financial resources to attend Harvard, affects students from middle and upper income families as well. Students and parents who may have thought they were financially autonomous upon graduation from college must negotiate new treaties of cooperation, to face a more prolonged dependency. As the *Statement of Financial Aid Policy* intones: "Even though some students have declared themselves independent of their parents, the financial resources of the parents, as well as those of the students, will be considered in determining the support to be made available from Medical School funds, and parents should expect to make contributions according to their means. The severe limitation on financial aid funds means that parents who have heretofore felt that their educational support of their children would cease at the end of the undergraduate years may have to reassess their thinking in this regard." There is no escaping this ultimate financial obligation, for it is decreed: "*No award will be made unless the parents' confidential statement accompanies the application.* This holds true even if you are married and responsible for your own support." Let the parents beware. HMS is hanging tough.

There are a few catches in the financial aid policy. First, although no funds are available through the Medical School for the support of spouses and/or children, a spouse's income may be used to reduce the amount of loan money awarded. Second, students on financial aid are encouraged to work at part-time jobs; unfortunately, many people find these opportunities financially unrewarding, stultifying, and an academic liability. The sum of $750 is suggested as respectable earnings for the summer prior to matriculation. Finally, although the Health Manpower Bill of 1976 has made provisions for scholarships and loan forgiveness programs, regulations and funding to implement the law have been delayed, creating a climate of uncertainty.

Fortunately, in difficult times, steady leaders may emerge; Harvard is graced with at least two. Guarding the student against fiscal chaos is the team of James Pates, assistant dean of student affairs, and his colleague, administrative assistant June McFee. Saddled with the task of unraveling personal and financial issues, they are regarded as well informed, reliable and fair. Their biggest fans seem to be those students in greatest financial need, who therefore qualify for scholarships as well as loans. In Pates's office hangs a photograph of Winston Churchill, jaws clenched against adversity. It must be tough to be a financial aid officer.

Being free from debt was formerly considered a virtue. If borrowers many of us must be, perhaps there is some solace in statistics which show that the burden is now being shared more democratically. For instance, of the 108 students in the class of 1980 receiving a "financial aid package," according to Mr. Pates, fifty are new borrowers; those fifty-eight who applied for financial subsidies before medical school arrived at Harvard already owing between $360 and $8,790, with an average debt of $3,225. Students receive financial aid according to relative need, with previous educational debts being taken into account. Thus, all students should graduate with roughly the same magnitude of debt. In practice, however, some latitude exists.

Medical students without money are no worse off than anyone else without money. Only the ordeals of education seem to heighten the sensation of indigence. How do students feel about their debt? What do they worry about?

One complaint is housing. The money provided is inadequate to live in a safe area, especially for married students or couples with children. Suggestions on where to live are inconsistent with the amount awarded. One married student started out in an apartment that rented for $165 a month. After he was twice robbed, he moved to the relative safety of Brookline. He bitterly referred to his $100 per month rent increase as a "mugger's fee."

Although military scholarships are appealing, doubts about future location, freedom of choice for residency training, and opportunities for one's spouse to do professional work in a remote area are considered drawbacks. Other family problems compound financial difficulties. One student remarked that he and his wife would be able to start a family several years sooner if he had gone to a state university. A woman student echoed the same theme. The onset of adulthood is delayed. Rent payments exceed house payments, but who can afford a home?

Part-time and summer jobs are deemed unsatisfactory. They are described as being not worthwhile, not remunerative, and a drain on time that could be spent with family or on academic work. One woman groused about having to balance working all summer to earn eight hundred dollars against taking her first vacation in eight years. Financial aid rules require that she work if she can.

Students are dismayed that they have to think more about money than they wanted to when they entered the profession. Those who wanted security but not wealth are now thinking heavily about ways to pay their debts. Will today's students become medical mercenaries? No one interviewed said he or she would change choice of specialty for financial reasons. Students are stubborn. Many believe in national health insurance but fear they could be part of a transitional generation of doctors with high educational debts, low chances of repaying them. Delay and trepidation about the availability of funds intensify these feelings.

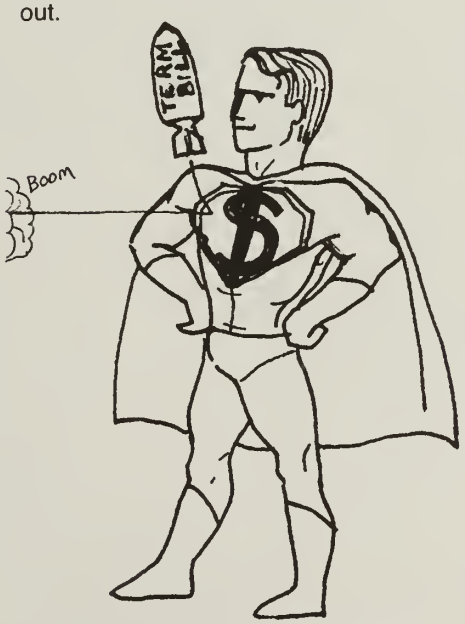
There are other sources of help besides Harvard loans and scholarships. In adversity, students must be flexible. The following solutions have been tried by members of the Class of 1979. Like the students themselves, they are highly idiosyncratic.

Be a Jesuit priest. Father James Distelhorst, S.J., is having his fees and living expenses paid for by his order; later on, they will help him dispose of any superfluous cash he may receive, thus maintaining a steady state.

Get married. One student reported that she and her husband are living off the latter's part-time salary and a generous fund of wedding presents. You have to invite the right people to your wedding.

Delay gratification. Students from middle income families who help with tuition may take out $20,000 in loans, and receive no scholarship. While people see this program as equitable, there are grumblings about the cost (and taste) of low-grade hamburger and other necessities of life.

Be stoical. One optimist who described himself as coming from a thoroughly nonaffluent family, estimated that he would leave with a debt of sixteen to twenty thousand dollars, depending on tuition increases. How did he feel about such a debt? "Things could be worse," he said, "tuition at some schools is ten thousand a year." The debt would have no effect on his career choice, and he gave the financial aid office a one hundred per cent rating for helping him out.



Be patriotic. Leo Troy, a West Point graduate, spent three years as an army officer learning to blow up bridges before coming to medical school. Now his fees are paid by a handsome army scholarship. He also picked up some spare cash as a prosector for the anatomy department.

Be lucky. One woman qualified for an outside scholarship because of the astuteness of Mr. Pates, who remembered that her state of residence was not her state of birth. When funds became available for someone born in Massachusetts, Pates matched the student and the grant.

Be expedient. Another woman opted for a military scholarship because she felt the financial aid package was enough to subsist on, but not enough to live on. No military assignment, she felt, could be worse than four years of misery in Boston. She would rather take her chances as an active duty physician with the armed services, she said, than go through the "embarrassment of having to plead for funds at HMS."

Be thrifty. The author served as a naval officer before coming to medical school and saved tuition in advance; collecting G.I. Bill educational benefits and being married to a physician also make life easier.

Be independently wealthy. Avoid the problem altogether. Or attend medical school after succeeding in a lucrative first career. One woman is a former investment banker.

Supporting students is a long-term proposition. Scholarships have been provided by generations of Harvard Medical alumni, many of whom received help when they were students. Individuals supported by Harvard money actually look forward to the time when they will be solvent enough to make their own contributions. Said one woman who is in debt up to her eyeballs, "I couldn't afford to be here without scholarship. Of course I'm going to help others later on."

A classic example is Dr. Carl Walter, the surgical pedagogue, medical Horatio Alger, and grand curmudgeon who runs the alumni fund. He estimates that he has repaid his total scholarship aid at least one hundredfold since graduation in 1932. Anyone who wants to follow in Dr. Walter's footsteps had best have large shoes: at today's prices, such repayment could amount to over a million dollars.

Letters

Cancer coda

Your issue devoted to cancer efforts at Harvard was very well done. I was especially pleased to read Samuel Hellman's review of the Joint Center for Radiation Therapy, which is proving to be a valuable model for other institutions. The flexibility of this institution in responding to the needs of a complex community of patients and hospitals is a tribute to Dr. Hellman's organizational skills.

There is some important history which antedates Dr. Hellman's narrative. The initiator of the process that led to the formation of the Joint Center was Dr. Leonard W. Cronkhite, then general director of Children's Hospital Medical Center, who approached me as general director of Beth Israel Hospital when he was planning a multistory garage between our two institutions. He asked if Beth Israel would be interested in creating a joint radiotherapy facility underneath the garage. We responded with enthusiasm. At that time, New England Deaconess Hospital had begun planning for a facility to be located under Joslin Park. At the suggestion of Mr. Henry C. Meadow, Associate Dean, Dr. Cronkhite and I met with Mr. Lowry of the Deaconess to discuss the possibility of creating a shared facility among the three hospitals. This led to an agreement among the three institutions and a series of complex exchanges of bits of land and money. Children's and the Beth Israel reimbursed the Deaconess for architectural plans, which had to be scrapped. The city of Boston agreed to sell a warehouse to the Children's Cancer Research Foundation (the site of the present Dana Center). In turn CCRF made a small piece of that land available to complete the site for the Shields Warren Radiation Laboratories, constructed by the Deaconess, to be the intellectual focus of the radiation center-to-be. Over the many months of negotiation required for those actions, discussions had begun, with Boston Hospital for Women, Peter Bent Brigham Hospital and Children's Cancer Research Foundation about their eventual participation.

Soon thereafter, Dr. Abrams was selected as chairman of radiology and became a participant in what had been the longest running ad hoc committee in HMS's history — I believe it was nine years — to select a professor of radiation therapy. It became clear that that committee had merely been marking time, waiting for Dr. Hellman to do his internship, residency and further training before nominating him to the post, which he fills so admirably.

Sidney S. Lee, M.D.
Dr. Lee, who is associate dean at McGill University, was formerly associate dean for hospital programs at HMS. — Ed.

I was greatly interested in and pleased by the January/February number of the *Alumni Bulletin.* You have done a fine job putting together the story of cancer at Harvard. The diagram accompanying Kurt Isselbacher's article provides a very useful chart through the Harvard-related labyrinth. I was especially interested in the photograph of the Van de Graaf apparatus at the Huntington and in the photograph of Robley Evans's measuring of the watch dial worker. The editorial staff has done a fine research job in the field.

Shields Warren '23

Many compliments on the last two issues of the *Alumni Bulletin.* The November/December 1976 issue, containing a collection of poems, was delightful and the January/February 1977 issue on cancer was very informative. I trust the oncology department will be developed and I hope there will be some type of cleaning house. My retirement has been long enough so that I appreciate a current effort at appraisal to combat obsolescence.

Herbert W. Jones, Jr. '37

The Boylston prize money

I was glad to see the stimulus given to the Boylston Medical Society by its mention in the last edition of the *Bulletin.*

There was one error commonly made in all brief histories of the Society which was repeated in the *Bulletin* — namely, confusion between the Boylston Prize (for which there is a medal) and the Prize Student Essays.

In 1961 I discovered that the trust account for the once attractive Boylston Prize had not been drawn on since 1923. Dean Berry thereupon arranged to have the prize medal in gold awarded to *summa cum laude* graduates who, by virtue of their theses, did qualify for the award without stretching the terms of the trust too far.

I had assumed that the Fund would continue to be used for this purpose until recently a book from the Countway came across my desk bearing the bookplate "Gift from the Boylston Prize Fund."

Newton E. Hyslop, Jr. '61

Not Boston but Roxbury

As a Children's Hospital Medical Center trustee, I look forward to receiving and reading avidly the *Harvard Medical Alumni Bulletin.* It is stimulating reading and among other things it has always seemed to me that the tributes to distinguished doctors who have died are handled sensitively and graciously.

The tribute to Frank Berry is no exception, but as a fellow alumnus of his at Roxbury Latin School and as a life trustee of that ancient institution, founded by John Eliot in 1645, I would like to point out that it was Roxbury Latin School which Dr. Berry attended. It was not our distinguished sister institution behind the Lying-In Hospital, the Boston Latin School, which became part of the Boston school system in the nineteenth century. The Roxbury Latin School is located on eighty acres of what was the old Codman Estate in West Roxbury and is still independent.

Roxbury Latin has many distinguished sons active in the medical profession and in the sciences today. Our roster includes such well-known graduates as General Joseph Warren, R.L.S. 1755, Dr. Paul Dudley White, R.L.S. 1903 and James Bryant Conant, R.L.S. 1910.

David A. Mittell